SENTRONG SIGLA

RHU/HC Supervisory Package

- Introduction and General Instructions
- Supervisory Forms
  - Program Flowcharts and Checklist Section
  - Findings, Actions and Recommendations Section

May 2003

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Introduction

Supervision is the "process of directing and supporting staff so that they may effectively perform their duties". Thus, supervision can be considered as one of the key approaches in improving the quality in the delivery of health services through better performance of health care providers. Under the Sentrong Sigla (SS), one of the indicators of quality is the RHU/HC supervisory system. For SS level I, the concern is "internal supervision" wherein supervisory sessions are conducted between the RHU supervisor (usually the nurse) and the RHU supervisee (the midwife) within the same facility.

In relation to this, one of the tools designed for Sentrong Sigla is the SS Supervisory Package. This is designed to complement existing supervisory tools for public health programs considering the labor-intensive nature of health service delivery. Its objective is to serve as an evaluation guide to be used by the RHU supervisor in conducting internal supervision sessions with the RHU supervisee at the facility level focusing on four (4) public health programs, likewise referred to as "core" programs. Furthermore this form shall focus on supervisee performance (rather than on the individual) in the context of over-all program performance.

Organization of the Supervisory Package

The supervisory package is divided into:

I. Introduction and General Instructions

II. Supervisory Forms

A. Program Flow Charts and Checklists

As mentioned earlier, the form shall monitor performance on the following core programs:

1. Safe Motherhood/Family Planning
2. Child Care
3. Prevention and Control of Infectious Diseases
    a. Tuberculosis
    b. Dengue
    c. Malaria
    d. Filariasis
    e. Schistosomiasis
    f. Rabies
    g. Sexually Transmitted Infections
    h. Leprosy
    i. Soil Transmitted Helminthiasis
4. Promotion of Healthy Lifestyle

There shall be a corresponding flow chart and checklist per program. The flowchart summarizes the major steps in program implementation in sequential order while the checklist consists of sets of questions that assess and monitor program implementation.

B. Findings, Actions and Recommendations

In this section, the supervisor shall write down his notes on the supervisory session including his findings, actions taken and recommendations.

The Process of Supervision using the Supervisory Form

1. The supervisor shall make a supervisory plan for the facility reflecting the purpose and schedule of the supervisory session/s
2. During each supervisory session, the supervisor and supervisee shall initially discuss the purpose of the session and the program/s for assessment. Afterwards, they shall review the identified *program flow chart* to determine the aspects of program implementation for assessment.
3. After identifying the areas for assessment, the supervisor shall evaluate the activities undertaken in detail by the service provider/s (usually the midwife) by using the corresponding *program checklist*.
4. To complete the process of supervision, the problems and opportunities identified during the supervisory session, as well as the actions taken and recommendations are noted in the Findings, Actions and Recommendations Section of the form.

Frequency of Supervisory Sessions

It is recommended that supervisory sessions on all core programs be conducted and completed using this form at least once every quarter or as often necessary.

Instructions in Using the Program Checklist

In the program checklist section of the supervisory form, there are sets of questions per program area for assessment. For each question, tick the appropriate box to indicate the corresponding answer – YES or NO.

Example:

FAMILY PLANNING	YES	NO
1. Does the midwife greet the client/couple warmly?	/	
2. Does the midwife use the Client Record Form or FP Form 1?	/	
3. Does the midwife obtain all pertinent personal, medical and social history of the client? a. Name, age, marital status b. FP use now and in the past c. Basic medical information (e.g. past medical history, family history, history of allergy; ask client about disease condition starting from head down to foot) d. History of smoking, alcohol and drug intake		/

During a supervisory session for Family Planning with the RHU midwife, the Nurse-Supervisor observed that the midwife greets FP clients/couples warmly upon entry into the FP room (1). Upon checking the RHU FP records, the supervisor found out that although the FP Form I was being used by the midwife (2), pertinent information on the client/couple personal, medical and social history were lacking such as the basic medical information (3.c. - family and past medical history) and history of smoking, alcohol and drug use (3.d).

Instructions in Accomplishing the Findings, Actions and Recommendations Section

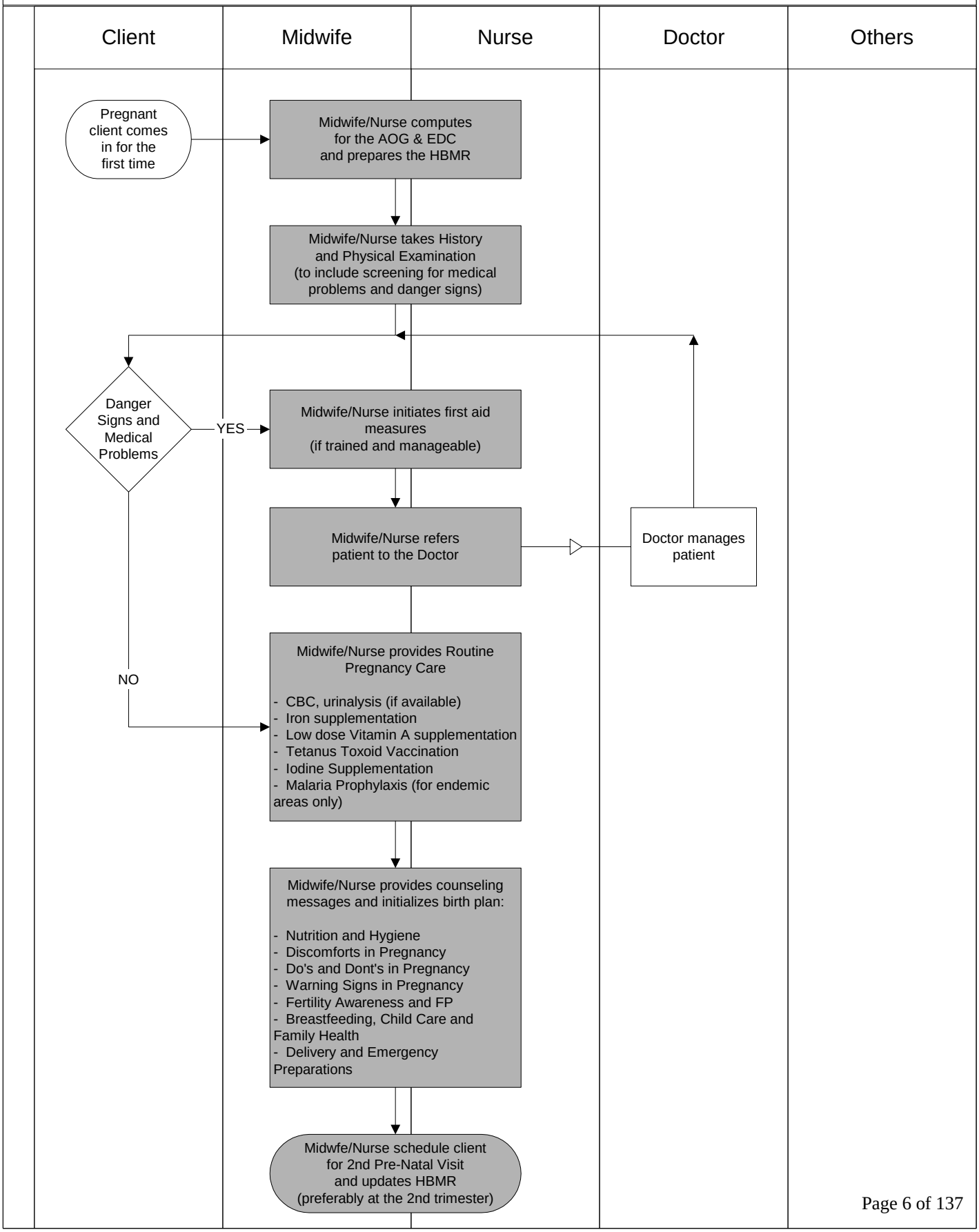
After accomplishing the program checklist the supervisor puts down his notes in writing. The columns of this section are filled up as follow:

1. Date - write the date (month, day, year) the supervisory session was conducted (not the date the supervisor's notes were accomplished).
2. Area – write the program and question number in the checklist where problems/opportunities where identified.
3. Findings – write both positive and negative findings. Negative findings should include identified problems or areas for improvement. For brevity, only general findings should be written.
4. Actions Taken – write what were the actions taken by the supervisor and the supervisee to address the findings at the time of the supervisory session.
5. Recommendations – write down the future steps for the supervisor/supervisee on how to further address the findings.

Example:
The table below shows supervisor's notes during the supervisory session on July 2, 2002

Date	Area	Findings	Actions Taken	Recommendation/s
July	Family Planning	- No information on	- reviewed with	- draft notes to
2,	# 3.c and 3.d	basic medical	midwife what	serve as guide in
2002		history and smoking	pertinent	history taking
		alcohol and drug	information to	
		use indicated in.	ask in eliciting	-schedule follow-up
		RHU FP records.	personal, medical	visit
			and social history	

Safe Motherhood
RHU Supervisory Flowchart: 1st Trimester Prenatal Visit (4 to 16 weeks)



Safe Motherhood
RHU/HC Supervisory Checklist for First Trimester Prenatal Visit (4 to 16 weeks)

A. Midwife Computes for the AOG and EDC and Prepares the HBMR	YES	NO	N/A
1. Does the midwife have a working knowledge on the acronyms used in pregnancy?			
a. LMP: refers to the last normal menstrual period; the month, day (first day of the LMP) and year.			
b. EDC: refers to the expected date of confinement, which is when the woman is due to deliver.			
c. AOG: refers to age of gestation and is the number of months (weeks) since the LMP.			
2. Does the midwife calculate the EDC using the calendar wheel by counting 3 months backwards (counter-clockwise) from LMP and adding 7 days?			
3. Does the midwife estimate the AOG using the calendar wheel by counting the number of months following (clockwise) LMP up to the date of the prenatal visit?			
4. Does the midwife estimate the EDC and AOG through the recommended methods if the woman does not know her LMP?			
a. The size of the uterus: at the level of the symphysis pubis – 3 months (12 weeks); at the level of the umbilicus – 5 months (20 weeks); at the level of the diaphragm – 9 months (36-38 weeks).			
b. To estimate the EDC: count (clockwise) 4 months from the date of quickening.			
c. To estimate the AOG: 5 + the number of months from the date of quickening to the prenatal visit.			

B. Midwife Takes History and Physical Examination (to include medical screening for medical problems and danger signs)	YES	NO	N/A
1. Does the midwife obtain the client's obstetrical history?			
a. Number of previous pregnancies.			
b. Previous caesarian section.			
c. 3 consecutive abortion and/or miscarriages.			
d. Stillbirth.			
e. Postpartum hemorrhage.			
2. Does the midwife weigh the woman in kilograms?			
3. Does the midwife measure and record the height of the mother in centimeters or inches?			
4. Does the midwife take the blood pressure of the pregnant woman according to the recommended procedures?			
5. Does the midwife take the pregnant woman's temperature?			
6. Does the midwife check for pallor by looking at the mucous membranes of the lower eyelid, mouth and the palms of her hand?			
7. Does the midwife ask for vaginal itching, burning or abnormal vaginal discharge?			
8. Does the midwife ask for symptoms of pain when urinating and the need to urinate frequently?			
9. Does the midwife elicit information on present health problems considered as risk factors?			
a. Tuberculosis/cough of 2 weeks or more.			
b. Heart disease.			
c. Diabetes.			

	YES	NO	N/A
d. Bronchial asthma.			
e. Goiter.			
10. Does the midwife examine and screen for risk factors for a pregnant woman?			
a. An age less than 18 or greater than 35 years old.			
b. Being less than 145 cm (4'9") tall.			
c. Having had one or more of the following:			
i. Previous caesarian section.			
ii. 3 consecutive miscarriages.			
iii. Postpartum hemorrhage.			
d. Having one or more of the following medical conditions:			
i. Tuberculosis			
ii. Heart disease			
iii. Diabetes			
iv. Bronchial asthma			
v. Goiter			
11. Does the midwife examine and screen the pregnant woman for danger signs that develop during the course of pregnancy?			
a. Any type of vaginal bleeding.			
b. Headache, dizziness, blurred vision.			
c. Puffiness of the face and hands.			
d. Being pale or anemic.			

C. Midwife Initiates First Aid Measures (if trained and manageable) for Danger Signs and Medical Problems	YES	NO	N/A
1. Does the midwife consider the following as signs and symptoms of probable causes of vaginal bleeding and provide appropriate action if trained and the case is manageable?			
a. Fever and/or foul smelling vaginal discharge			
i. Probable cause: Septic abortion			
ii. Action:			
1. Give Amoxycillin 1 gram PO.			
2. Fluid Replacement.			
3. Paracetamol 500 mg PO if there is fever.			
4. Refer immediately to doctor/hospital.			
b. Profuse bleeding with passage of clots			
i. Probable cause: Incomplete abortion or molar pregnancy			
ii. Action:			
1. Give Ergometrine 0.2 mg IM.			
2. Fluid replacement.			
3. Refer immediately to a doctor/hospital with a friend or relative willing to donate blood.			

	YES	NO	N/A
c. Profuse bleeding which has now stopped			
i. Probable cause: Completed abortion			
ii. Action			
1. Advise rest for 3 days.			
2. Fluid replacement.			
3. Give ferrous sulfate 60 mg with folic acid 2 tablets daily for 2 months.			
4. Give advise on family planning.			
5. If the mother is very pale, refer to doctor/hospital for possible transfusion.			
d. Spotting only			
i. Probable cause: Threatened abortion			
ii. Action			
1. Advise bed rest for 3 days after the bleeding has stopped.			
2. Advise avoidance of sexual intercourse for 1 week after the bleeding has stopped.			
3. Refer immediately to doctor/hospital if bleeding and/or pain gets worse or if bleeding continues for more than one week.			
2. Does the midwife refrain from doing an internal examination on a woman with bleeding?			
3. Does the midwife give 60 mg elemental iron with folic acid 2 tablets daily to a client with pallor?			

D. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer clients with danger signs and medical problems to the doctor/hospital for further evaluation and management?			
2. Does the midwife refer pregnant women with risk factors to the doctor for further evaluation and management?			

E. Midwife Provides Routine Pregnancy Care	YES	NO	N/A
1. Does the midwife request for CBC and urinalysis if available?			
2. Does the midwife give 60 mg elemental iron with folic acid 2 tablets daily to a client with pallor regardless of AOG?			
3. Does the midwife give iron supplementation on the 5th month of pregnancy until 2 months postpartum if client is not pale/anemic?			
4. Does the midwife give low dose Vitamin A supplementation (10,000 IU in two weeks)?			
5. Does the midwife give 5 injections (each of 0.5 ml IM) of tetanus toxoid to all clients according to the following schedule:			
a. TT1: First contact (even in first trimester)			
b. TT2: 1 month after TT1			
c. TT3: 6 months after TT2			
d. TT4: 1 year after TT3			
e. TT5: 1 year after TT4			
6. Does the midwife give 1 iodized oil capsule to all pregnant clients in areas where goiter is endemic?			
7. Does the midwife give 2 tablets of chloroquine phospate (250 mg /tablet) every week for the duration of pregnancy in malaria endemic areas?			

	YES	NO	N/A
8. Does the midwife do an internal examination when indicated?			

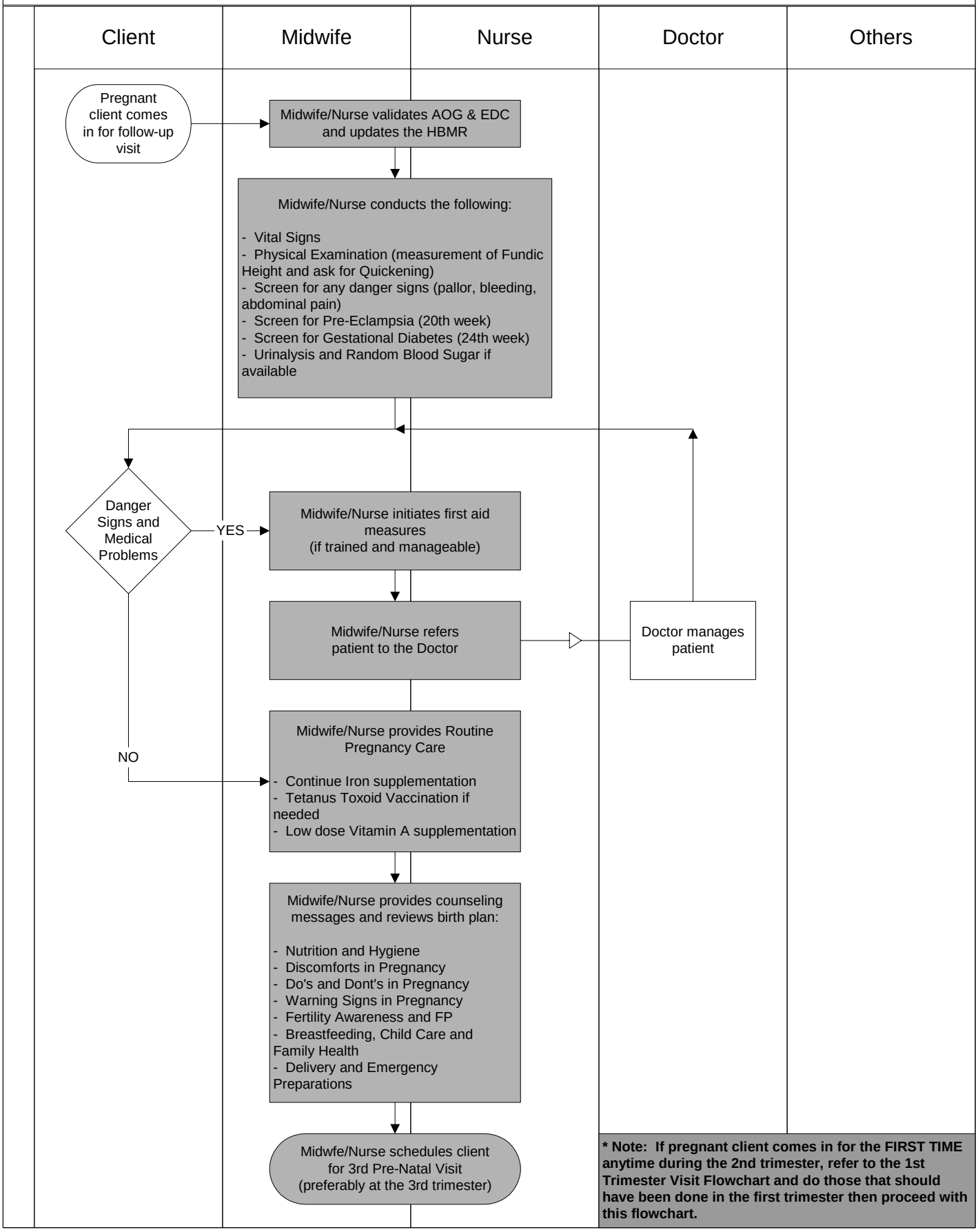
F. Midwife Provides Counseling Messages and Initializes Birth Plans	YES	NO	N/A
1. Does the midwife counsel the client on proper nutrition and hygiene during pregnancy?			
2. Does the midwife counsel the client on the discomforts in pregnancy?			
a. Constipation			
• Increase her usual fluid intake by 2 to 4 glasses per day.			
• Eat lots of fruits and vegetables.			
• Walk.			
• Avoid straining during bowel movements.			
b. Hemorrhoids			
• Sit only on hard surfaces.			
• Avoid constipation.			
• Lie with hips on a few pillows for about 10 minutes twice a day.			
c. Heartburn or indigestion			
• Eat small, frequent meals instead of three large ones.			
• Limit spicy or greasy foods.			
• Avoid lying down right after eating.			
• Eat papaya.			
• Don't drink with meals; try to drink 30 minutes before or after meals.			
d. Morning sickness/Nausea and vomiting			
• Eat small, frequent meals instead of three large ones.			
• Don't drink with meals; try to drink 30 minutes before and after meals.			
• Eat bread or crackers before getting up in the morning.			
• Suck on cracked ice or ice chips.			
e. Varicose veins			
• Keep legs up when sitting.			
• Walk and try to move around.			
• Avoid socks or stockings with elastic tops.			
f. Vaginal itchiness/White cheesy discharge			
• Wear cotton and loose underwear.			
• Frequently change underwear.			
• Avoid sweets.			
• Avoid wearing tight pants especially jeans.			
• Wash the vagina with water plus vinegar (1 part vinegar to 1 part water) 3 times a day for 1 week.			

	YES	NO	N/A
g. Leg cramps			
• Keep feet and legs elevated whenever possible.			
• Lightly massage the lower legs.			
• If leg cramps, have the mother straighten her knee and bend her foot back towards her leg or suggest that she stand up on cramping leg.			
• Drink lots of fluid.			
h. Backache			
• Always straighten back when standing or sitting, do not slouch.			
• Wear low-heeled shoes.			
• Massage the affected area.			
• Do pelvic rocks for exercise.			
1. Start from any of these positions: standing with legs slightly apart; lying supine with knees flexed and slightly apart; or getting down on your hands and knees.			
2. Curl the lower back and hold it for a few seconds.			
3. Straighten the lower back.			
4. Repeat the movement 20 to 25 times.			
3. Does the midwife counsel on the Do's and Don't's in pregnancy?			
a. Warn her to refrain from smoking (whether active or passive) and from drinking alcoholic beverages.			
b. Warn her to avoid exposure to insecticides.			
c. Tell her to consult immediately for any complaints and not to resort to self-medication.			
d. Reassure her that it's alright to have sexual intercourse unless she has a history or preterm labor.			
4. Does the midwife counsel the client on the danger signs of pregnancy?			
a. Vaginal bleeding.			
b. Headache, dizziness and blurring of vision.			
c. Puffiness of the face and hands.			
d. Being pale or anemic.			
5. Does the midwife counsel the client on fertility awareness and family planning?			
6. Does the midwife counsel the client on breastfeeding?			
a. Practice the 3 E's			
• Early: mother should start right after delivery.			
• Exclusive: mother will feed her baby only on breast milk up to 6 months.			
• Extended: mother should continue for 2 years.			
b. Facts on breastfeeding			
• Breast milk alone is the best food for her baby in the first 6 months of life.			
1. Giving other food or drink can be dangerous.			
2. Breast milk helps to protect the baby against diarrhea and cough and colds.			

	YES	NO	N/A
• Almost all mothers can produce enough milk for their baby if they:			
1. Let the baby suck as often as he likes (on demand), day and night.			
2. Use both breasts at each feeding.			
3. Even if a woman has inverted nipples, she can breastfeed.			
• Bottle feeding may lead to serious illness and even death for the baby:			
1. Bottle feeding can cause illness such as diarrhea if the water is not boiled and the nipple is not sterilized for each feeding.			
• Crying after breastfeeding is not a sign that a baby needs formula or other solutions. It normally means that the baby wants to be held and cuddled more. Some babies need to suck the breast simply for comfort.			
7. Does the midwife counsel the client on child care and family health?			
8. Does the midwife initialize with client birth plans?			
a. Discuss with the client how she can get to the hospital if there is an emergency.			
b. Advise her to put aside some money in case of an emergency and for delivery.			
c. Discuss with her where she intends to deliver her baby.			
d. Tell her what to prepare for the delivery and for her baby.			

G. Midwife Schedules Client for 2nd Prenatal Visit and Updates HBMR	YES	NO	N/A
1. Does the midwife schedule the client for 2nd prenatal visit preferably at the 2nd trimester?			
2. Does the midwife update the HBMR?			

Safe Motherhood
RHU Supervisory Flowchart: 2nd Trimester Prenatal Visit (17 to 28 weeks)



Safe Motherhood
RHU/HC Supervisory Checklist for Second Trimester Prenatal Visit (17 to 28 weeks)

z

A. Midwife Validates AOG and EDC and Updates the HBMR	YES	NO	N/A
1. Does the midwife have a working knowledge on the acronyms used in pregnancy?			
a. LMP: refers to the last normal menstrual period; the month, day (first day of the LMP) and year.			
b. EDC: refers to the expected date of confinement, which is when the woman is due to deliver.			
c. AOG: refers to age of gestation and is the number of months (weeks) since the LMP.			
2. Does the midwife validate the EDC using the calendar wheel by counting 3 months backwards (counter-clockwise) from LMP and adding 7 days?			
3. Does the midwife validate the AOG using the calendar wheel by counting the number of months following (clockwise) LMP up to the date of the prenatal visit?			
4. Does the midwife validate the EDC and AOG through the recommended methods if the woman does not know her LMP?			
a. The size of the uterus: at the level of the symphysis pubis – 3 months (12 weeks); at the level of the umbilicus – 5 months (20 weeks); at the level of the diaphragm – 9 months (36-38 weeks).			
b. To estimate the EDC: count (clockwise) 4 months from the date of quickening.			
c. To estimate the AOG: 5 + the number of months from the date of quickening to the prenatal visit.			
5. Does the midwife update the client's HBMR?			

B. Midwife Conducts the Following…	YES	NO	N/A
1. Does the midwife weigh the woman in kilograms?			
2. Does the midwife take the blood pressure of the pregnant woman according to the recommended procedures			
3. Does the midwife take the pregnant woman's temperature?			
4. Does the midwife check for pallor by looking at the mucous membranes of the lower eyelid, mouth and the palms of her hand?			
5. Does the midwife ask for vaginal itching, burning or abnormal vaginal discharge?			
6. Does the midwife ask for symptoms of pain when urinating and the need to urinate frequently?			
7. Does the midwife measure the fundic height with a tape measure from the symphysis pubis to the uterine fundus?			
8. Does the midwife ask for the date when the woman first noticed her baby moving (quickening)?			
9. Does the midwife examine and screen the pregnant woman for danger signs that develop during the course of pregnancy?			
a. Any type of vaginal bleeding.			
b. Abdominal pain.			
c. Being pale or anemic.			
10. Does the midwife screen for pre-eclampsia preferably on the 20th week by looking for the presence of protein in routine urinalysis?			

11. Does the midwife screen the following types of clients for diabetes:	YES	NO	N/A
a. Mothers found to have sugar in their urine.			
b. Mothers with personal or family history of diabetes.			
c. Mothers with signs and symptoms of diabetes like passing a lot of urine and drinking a lot.			
d. Mothers with a large previous baby.			
e. Mothers with a previous unexplained stillbirth.			

C. Midwife Initiates First Aid Measures (if trained and manageable) for Danger Signs and Medical Problems	YES	NO	N/A
1. Does the midwife, if trained and the case is manageable, initiate first aid measures for danger signs and medical problems encountered during the second trimester visit?			
a. Pallor			
b. Vaginal bleeding			
c. Abdominal pain			

D. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer clients with danger signs and medical problems to the doctor/hospital for further evaluation and management?			

E. Midwife Provides Routine Pregnancy Care	YES	NO	N/A
1. Does the midwife give 60 mg elemental iron with folic acid 2 tablets daily to a client with pallor regardless of AOG?			
2. Does the midwife give iron supplementation on the 5th month of pregnancy until 2 months postpartum if client is not pale/anemic?			
3. Does the midwife give 5 injections (each of 0.5 ml IM) of tetanus toxoid to all clients according to the following schedule:			
a. TT1: First contact (even in first trimester)			
b. TT2: 1 month after TT1			
c. TT3: 6 months after TT2			
d. TT4: 1 year after TT3			
e. TT5: 1 year after TT4			

F. Midwife Provides Counseling Messages and Reviews Birth Plans	YES	NO	N/A
1. Does the midwife reinforce counseling messages on proper nutrition and hygiene during pregnancy?			
2. Does the midwife reinforce counseling messages on the discomforts in pregnancy?			
a. Constipation			
• Increase her usual fluid intake by 2 to 4 glasses per day.			
• Eat lots of fruits and vegetables.			
• Walk.			
• Avoid straining during bowel movements.			

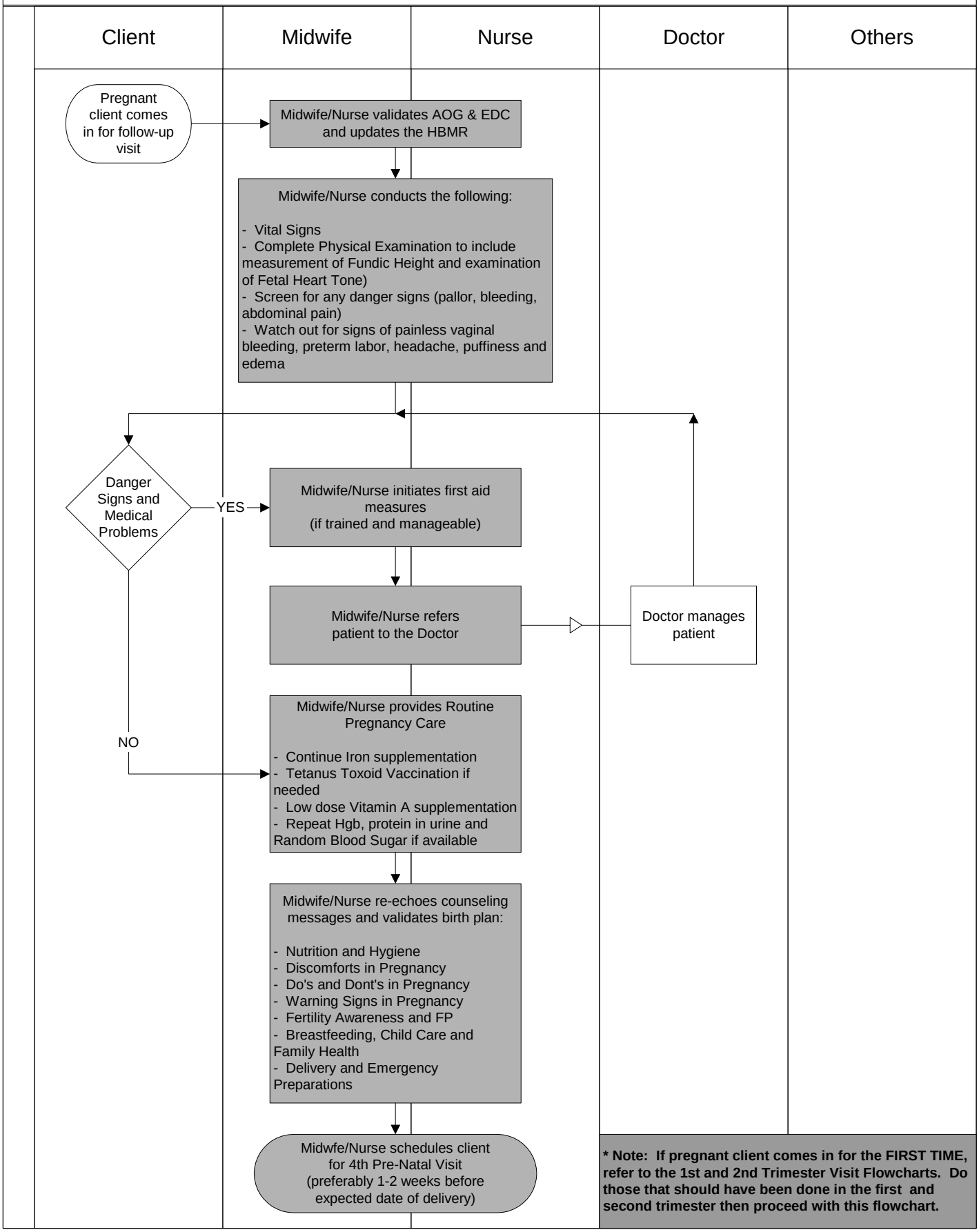
b. Hemorrhoids	YES	NO	N/A
• Sit only on hard surfaces.			
• Avoid constipation.			
• Lie with hips on a few pillows for about 10 minutes twice a day.			
c. Heartburn or indigestion			
• Eat small, frequent meals instead of three large ones.			
• Limit spicy or greasy foods.			
• Avoid lying down right after eating.			
• Eat papaya.			
• Don't drink with meals; try to drink 30 minutes before or after meals.			
d. Morning sickness/Nausea and vomiting			
• Eat small, frequent meals instead of three large ones.			
• Don't drink with meals; try to drink 30 minutes before and after meals.			
• Eat bread or crackers before getting up in the morning.			
• Suck on cracked ice or ice chips.			
e. Varicose veins			
• Keep legs up when sitting.			
• Walk and try to move around.			
• Avoid socks or stockings with elastic tops.			
f. Vaginal itchiness/White cheesy discharge			
• Wear cotton and loose underwear.			
• Frequently change underwear.			
• Avoid sweets.			
• Avoid wearing tight pants especially jeans.			
• Wash the vagina with water plus vinegar (1 part vinegar to 1 part water) 3 times a day for 1 week.			
g. Leg cramps			
• Keep feet and legs elevated whenever possible.			
• Lightly massage the lower legs.			
• If leg cramps, have the mother straighten her knee and bend her foot back towards her leg or suggest that she stand up on cramping leg.			
• Drink lots of fluid.			
h. Backache			
• Always straighten back when standing or sitting, do not slouch.			
• Wear low-heeled shoes.			
• Massage the affected area.			

	YES	NO	N/A
• Do pelvic rocks for exercise.			
o Start from any of these positions: standing with legs slightly apart; lying supine with knees flexed and slightly apart; or getting down on your hands and knees.			
o Curl the lower back and hold it for a few seconds.			
o Straighten the lower back.			
o Repeat the movement 20 to 25 times.			
3. Does the midwife reinforce counseling messages on the Do's and Don't's in pregnancy?			
a. Warn her to refrain from smoking (whether active or passive) and from drinking alcoholic beverages.			
b. Warn her to avoid exposure to insecticides.			
c. Tell her to consult immediately for any complaints and not to resort to self-medication.			
d. Reassure her that it's alright to have sexual intercourse unless she has a history or preterm labor.			
4. Does the midwife reiterate the danger signs of pregnancy?			
a. Vaginal bleeding.			
b. Headache, dizziness and blurring of vision.			
c. Puffiness of the face and hands.			
d. Being pale or anemic.			
5. Does the midwife reinforce counseling messages on fertility awareness and family planning?			
6. Does the midwife reinforce counseling messages on breastfeeding?			
a. Practice the 3 E's			
• Early: mother should start right after delivery.			
• Exclusive: mother will feed her baby only on breast milk up to 6 months.			
• Extended: mother should continue for 2 years.			
b. Facts on breastfeeding			
• Breast milk alone is the best food for her baby in the first 6 months of life.			
o Giving other food or drink can be dangerous.			
o Breast milk helps to protect the baby against diarrhea and cough and colds.			
• Almost all mothers can produce enough milk for their baby if they:			
o Let the baby suck as often as he likes (on demand), day and night.			
o Use both breasts at each feeding.			
o Even if a woman has inverted nipples, she can breastfeed.			
• Bottle feeding may lead to serious illness and even death for the baby:			
o Bottle feeding can cause illness such as diarrhea if the water is not boiled and the nipple is not sterilized for each feeding.			
• Crying after breastfeeding is not a sign that a baby needs formula or other solutions. It normally means that the baby wants to be held and cuddled more. Some babies need to suck the breast simply for comfort.			
7. Does the midwife reinforce counseling messages on child care and family health?			

8. Does the midwife review with the client the birth plans?	YES	NO	N/A
a. Discuss with the client how she can get to the hospital if there is an emergency.			
b. Advise her to put aside some money in case of an emergency and for delivery.			
c. Discuss with her where she intends to deliver her baby.			
d. Tell her what to prepare for the delivery and for her baby.			

G. Midwife Schedules Client for 3rd Prenatal Visit	YES	NO	N/A
1. Does the midwife schedule the client for 3rd prenatal visit preferably at the 3rd trimester?			
2. Does the midwife update the HBMR?			

Safe Motherhood
RHU Supervisory Flowchart: 3rd Trimester Prenatal Visit (29 to 36 weeks)



Safe Motherhood
RHU/HC Supervisory Checklist for Third Trimester Prenatal Visit (29 to 36 weeks)

A. Midwife Validates AOG and EDC and Updates the HBMR	YES	NO	N/A
1. Does the midwife have a working knowledge on the acronyms used in pregnancy?			
a. LMP: refers to the last normal menstrual period; the month, day (first day of the LMP) and year.			
b. EDC: refers to the expected date of confinement, which is when the woman is due to deliver.			
c. AOG: refers to age of gestation and is the number of months (weeks) since the LMP.			
2. Does the midwife validate the EDC using the calendar wheel by counting 3 months backwards (counter-clockwise) from LMP and adding 7 days?			
3. Does the midwife validate the AOG using the calendar wheel by counting the number of months following (clockwise) LMP up to the date of the prenatal visit?			
4. Does the midwife validate the EDC and AOG through the recommended methods if the woman does not know her LMP?			
a. The size of the uterus: at the level of the symphysis pubis – 3 months (12 weeks); at the level of the umbilicus – 5 months (20 weeks); at the level of the diaphragm – 9 months (36-38 weeks).			
b. To estimate the EDC: count (clockwise) 4 months from the date of quickening.			
c. To estimate the AOG: 5 + the number of months from the date of quickening to the prenatal visit.			
6. Does the midwife update the client's HBMR?			

B. Midwife Conducts the Following…	YES	NO	N/A
1. Does the midwife weigh the woman in kilograms?			
2. Does the midwife take the blood pressure of the pregnant woman according to the recommended procedures			
3. Does the midwife take the pregnant woman's temperature?			
4. Does the midwife check for pallor by looking at the mucous membranes of the lower eyelid, mouth and the palms of her hand?			
5. Does the midwife ask for vaginal itching, burning or abnormal vaginal discharge?			
6. Does the midwife ask for symptoms of pain when urinating and the need to urinate frequently?			
7. Does the midwife measure the fundic height with a tape measure from the symphysis pubis to the uterine fundus?			
8. Does the midwife examine the fetal heart tone with a stethoscope?			
9. Does the midwife examine and screen the pregnant woman for danger signs that develop during the course of pregnancy?			
a. Painless vaginal bleeding.			
b. Abdominal pain.			
c. Being pale or anemic.			
d. Preterm labor.			
e. Headache, puffiness and edema.			

C. Midwife Initiates First Aid Measures (if trained and manageable) for Danger Signs and Medical Problems	YES	NO	N/A
1. Does the midwife, if trained and the case is manageable, initiate first aid measures for danger signs and medical problems encountered during the third trimester visit?			
a. Painless vaginal bleeding.			
b. Abdominal pain.			
c. Being pale or anemic.			
d. Preterm labor.			
e. Headache, puffiness and edema.			

D. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer clients with danger signs and medical problems to the doctor/hospital for further evaluation and management?			

E. Midwife Provides Routine Pregnancy Care	YES	NO	N/A
1. Does the midwife continue iron supplementation?			
2. Does the midwife give 5 injections (each of 0.5 ml IM) of tetanus toxoid to all clients according to the following schedule:			
i. TT1: First contact (even in first trimester)			
j. TT2: 1 month after TT1			
k. TT3: 6 months after TT2			
l. TT4: 1 year after TT3			
m. TT5: 1 year after TT4			
3. Does the midwife request for repeat hemoglobin, urine protein and random blood sugar examinations if available?			

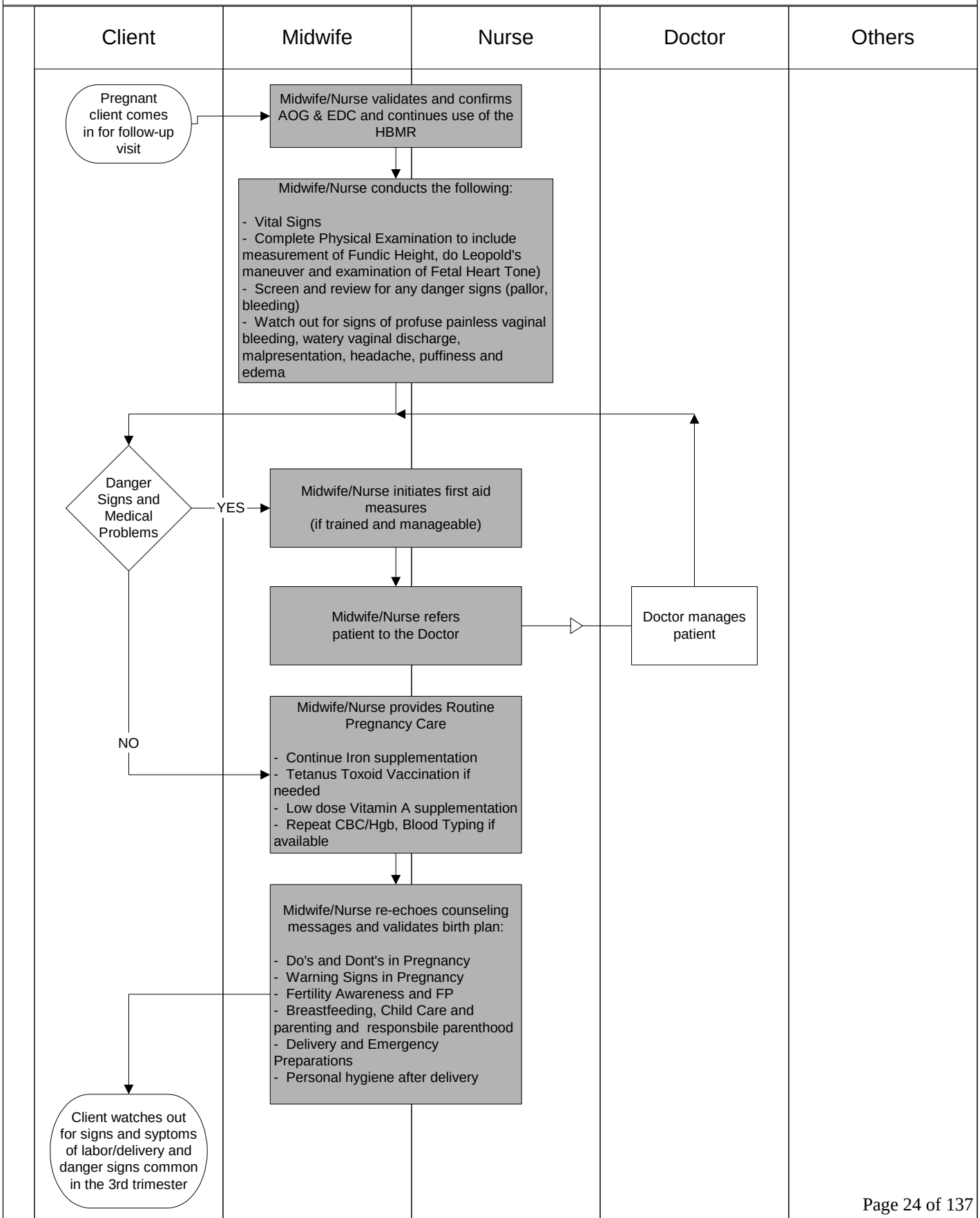
F. Midwife Provides Re-Echoes Counseling Messages and Validates Birth Plans	YES	NO	N/A
1. Does the midwife reinforce counseling messages on proper nutrition and hygiene during pregnancy?			
2. Does the midwife reinforce counseling messages on the discomforts in pregnancy?			
a. Constipation			
• Increase her usual fluid intake by 2 to 4 glasses per day.			
• Eat lots of fruits and vegetables.			
• Walk.			
• Avoid straining during bowel movements.			
b. Hemorrhoids	YES	NO	N/A
• Sit only on hard surfaces.			
• Avoid constipation.			
• Lie with hips on a few pillows for about 10 minutes twice a day.			
c. Heartburn or indigestion			
• Eat small, frequent meals instead of three large ones.			

	YES	NO	N/A
• Limit spicy or greasy foods.			
• Avoid lying down right after eating.			
• Eat papaya.			
• Don't drink with meals; try to drink 30 minutes before or after meals.			
d. Morning sickness/Nausea and vomiting			
• Eat small, frequent meals instead of three large ones.			
• Don't drink with meals; try to drink 30 minutes before and after meals.			
• Eat bread or crackers before getting up in the morning.			
• Suck on cracked ice or ice chips.			
e. Varicose veins			
• Keep legs up when sitting.			
• Walk and try to move around.			
• Avoid socks or stockings with elastic tops.			
n. Vaginal itchiness/White cheesy discharge			
• Wear cotton and loose underwear.			
• Frequently change underwear.			
• Avoid sweets.			
• Avoid wearing tight pants especially jeans.			
• Wash the vagina with water plus vinegar (1 part vinegar to 1 part water) 3 times a day for 1 week.			
o. Leg cramps			
• Keep feet and legs elevated whenever possible.			
• Lightly massage the lower legs.			
• If leg cramps, have the mother straighten her knee and bend her foot back towards her leg or suggest that she stand up on cramping leg.			
• Drink lots of fluid.			
p. Backache			
• Always straighten back when standing or sitting, do not slouch.			
• Wear low-heeled shoes.			
• Massage the affected area.			
• Do pelvic rocks for exercise.			
o Start from any of these positions: standing with legs slightly apart; lying supine with knees flexed and slightly apart; or getting down on your hands and knees.			
o Curl the lower back and hold it for a few seconds.			
o Straighten the lower back.			
o Repeat the movement 20 to 25 times.			
3. Does the midwife reinforce counseling messages on the Do's and Don't's in pregnancy?			
a. Warn her to refrain from smoking (whether active or passive) and from drinking alcoholic beverages.			

	YES	NO	N/A
b. Tell her to consult immediately for any complaints and not to resort to self-medication.			
c. Warn her to avoid exposure to insecticides.			
d. Reassure her that it's alright to have sexual intercourse unless she has a history or preterm labor.			
4. Does the midwife reiterate the danger signs of pregnancy?			
a. Painless vaginal bleeding.			
b. Abdominal pain.			
c. Being pale or anemic.			
d. Preterm labor.			
e. Headache, puffiness and edema.			
5. Does the midwife reinforce counseling messages on fertility awareness and family planning?			
6. Does the midwife reinforce counseling messages on breastfeeding?			
a. Practice the 3 E's			
• Early: mother should start right after delivery.			
• Exclusive: mother will feed her baby only on breast milk up to 6 months.			
• Extended: mother should continue for 2 years.			
b. Facts on breastfeeding			
• Breast milk alone is the best food for her baby in the first 6 months of life.			
o Giving other food or drink can be dangerous.			
o Breast milk helps to protect the baby against diarrhea and cough and colds.			
• Almost all mothers can produce enough milk for their baby if they:			
o Let the baby suck as often as he likes (on demand), day and night.			
o Use both breasts at each feeding.			
o Even if a woman has inverted nipples, she can breastfeed.			
• Bottle feeding may lead to serious illness and even death for the baby:			
o Bottle feeding can cause illness such as diarrhea if the water is not boiled and the nipple is not sterilized for each feeding.			
• Crying after breastfeeding is not a sign that a baby needs formula or other solutions. It normally means that the baby wants to be held and cuddled more. Some babies need to suck the breast simply for comfort.			
7. Does the midwife reinforce counseling messages on child care and family health?			
8. Does the midwife validate the client's birth plans?	YES	NO	N/A
a. Discuss with the client how she can get to the hospital if there is an emergency.			
b. Advise her to put aside some money in case of an emergency and for delivery.			
c. Discuss with her where she intends to deliver her baby.			
d. Tell her what to prepare for the delivery and for her baby.			

G. Midwife Schedules Client for 4th Prenatal Visit	YES	NO	N/A
1. Does the midwife schedule the client for 4th prenatal visit preferably 1 to 2 weeks before expected date of delivery?			

Safe Motherhood
RHU Supervisory Flowchart: 3rd Trimester Prenatal Visit (37 to 40 weeks)



Safe Motherhood
RHU/HC Supervisory Checklist for Third Trimester Prenatal Visit (37 to 40 weeks)

A. Midwife Validates and Confirms the AOG and EDC and Continues Use of the HBMR	YES	NO	N/A
1. Does the midwife have a working knowledge on the acronyms used in pregnancy?			
a. LMP: refers to the last normal menstrual period; the month, day (first day of the LMP) and year.			
b. EDC: refers to the expected date of confinement, which is when the woman is due to deliver.			
c. AOG: refers to age of gestation and is the number of months (weeks) since the LMP.			
2. Does the midwife validate and confirm the EDC using the calendar wheel by counting 3 months backwards (counter-clockwise) from LMP and adding 7 days?			
3. Does the midwife validate and confirm the AOG using the calendar wheel by counting the number of months following (clockwise) LMP up to the date of the prenatal visit?			
4. Does the midwife validate and confirm the EDC and AOG through the recommended methods if the woman does not know her LMP?			
a. The size of the uterus: at the level of the symphysis pubis – 3 months (12 weeks); at the level of the umbilicus – 5 months (20 weeks); at the level of the diaphragm – 9 months (36-38 weeks).			
b. To estimate the EDC: count (clockwise) 4 months from the date of quickening.			
c. To estimate the AOG: 5 + the number of months from the date of quickening to the prenatal visit.			
7. Does the midwife continue to use the HBMR?			

B. Midwife Conducts the Following…	YES	NO	N/A
1. Does the midwife weigh the woman in kilograms?			
2. Does the midwife take the blood pressure of the pregnant woman according to the recommended procedures			
3. Does the midwife take the pregnant woman's temperature?			
4. Does the midwife check for pallor by looking at the mucous membranes of the lower eyelid, mouth and the palms of her hand?			
5. Does the midwife ask for vaginal itching, burning or abnormal vaginal discharge?			
6. Does the midwife ask for symptoms of pain when urinating and the need to urinate frequently?			
7. Does the midwife measure the fundic height with a tape measure from the symphysis pubis to the uterine fundus?			
8. Does the midwife examine the fetal heart tone with a stethoscope?			
9. Does the midwife do the Leopold's Maneuver?			
a. Face the woman's head; with both hands, feel the height of the fundus and tell which part of the fetus you feel.			
b. Feel the sides of the uterus to find the position of the baby's back and extremities. The back feels smooth while the extremities feel irregular.			
c. Grasp the area above the symphysis pubis between thumb and fingers of your hand and identify the presenting part.			
d. Face the woman's feet. Place fingers on both sides of the lower abdomen and press downwards and inwards to identify the presenting part, find out the level and whether it is engaged.			

10. Does the midwife examine and screen the pregnant woman for danger signs that develop during the course of pregnancy?	YES	NO	N/A
a. Profuse painless vaginal bleeding.			
b. Pallor.			
c. Watery vaginal discharge.			
d. Malpresentation.			
e. Headache, puffiness and edema.			

C. Midwife Initiates First Aid Measures (if trained and manageable) for Danger Signs and Medical Problems	YES	NO	N/A
1. Does the midwife, if trained and the case is manageable, initiate first aid measures for danger signs and medical problems encountered during the third trimester visit?			
a. Profuse painless vaginal bleeding.			
b. Pallor.			
c. Watery vaginal discharge.			
d. Malpresentation.			
e. Headache, puffiness and edema.			

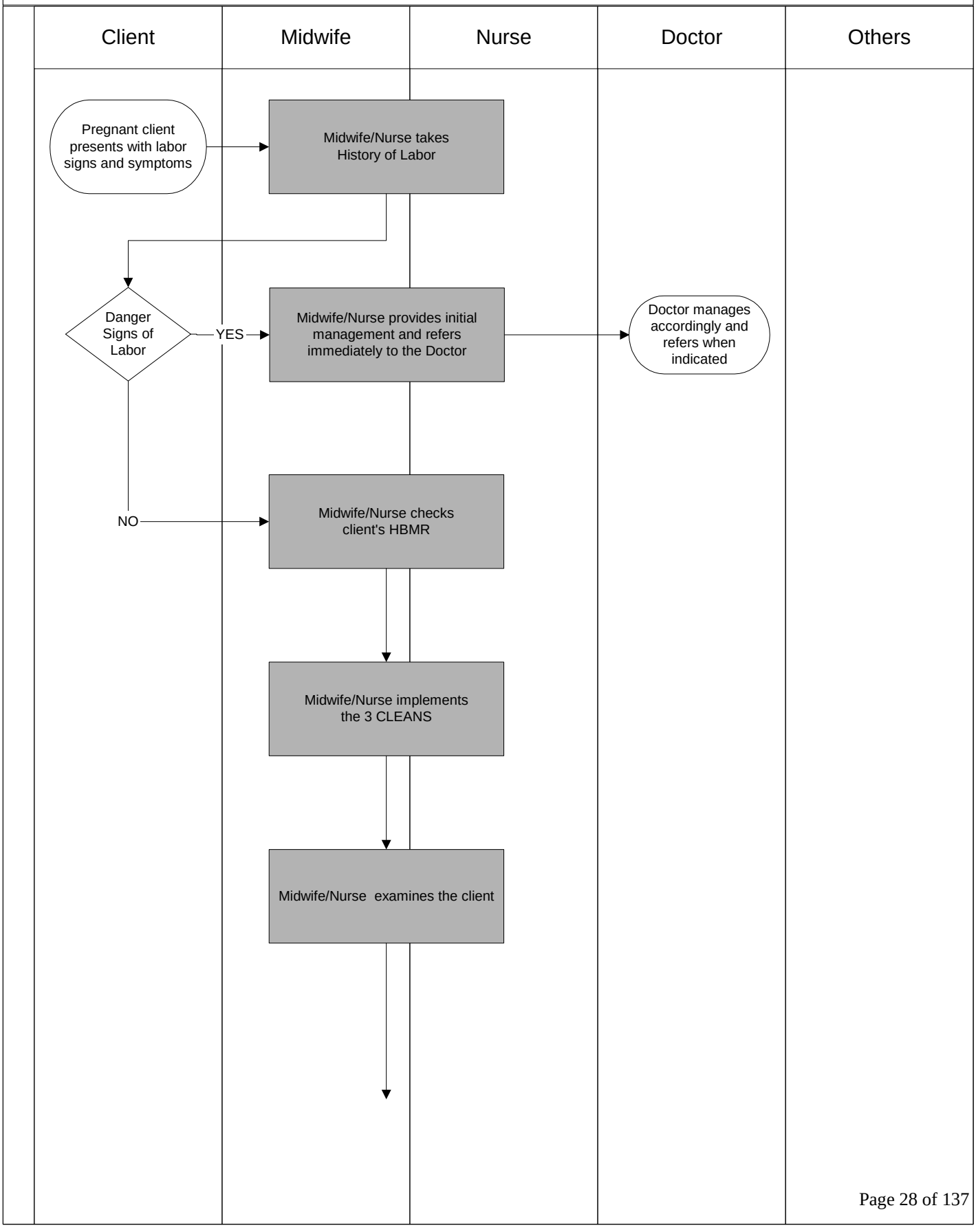
D. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer clients with danger signs and medical problems to the doctor/hospital for further evaluation and management?			

E. Midwife Provides Routine Pregnancy Care	YES	NO	N/A
1. Does the midwife continue iron supplementation?			
2. Does the midwife give 5 injections (each of 0.5 ml IM) of tetanus toxoid to all clients according to the following schedule:			
a. TT1: First contact (even in first trimester)			
b. TT2: 1 month after TT1			
c. TT3: 6 months after TT2			
d. TT4: 1 year after TT3			
e. TT5: 1 year after TT4			
3. Does the midwife request for repeat hemoglobin and blood typing if available?			

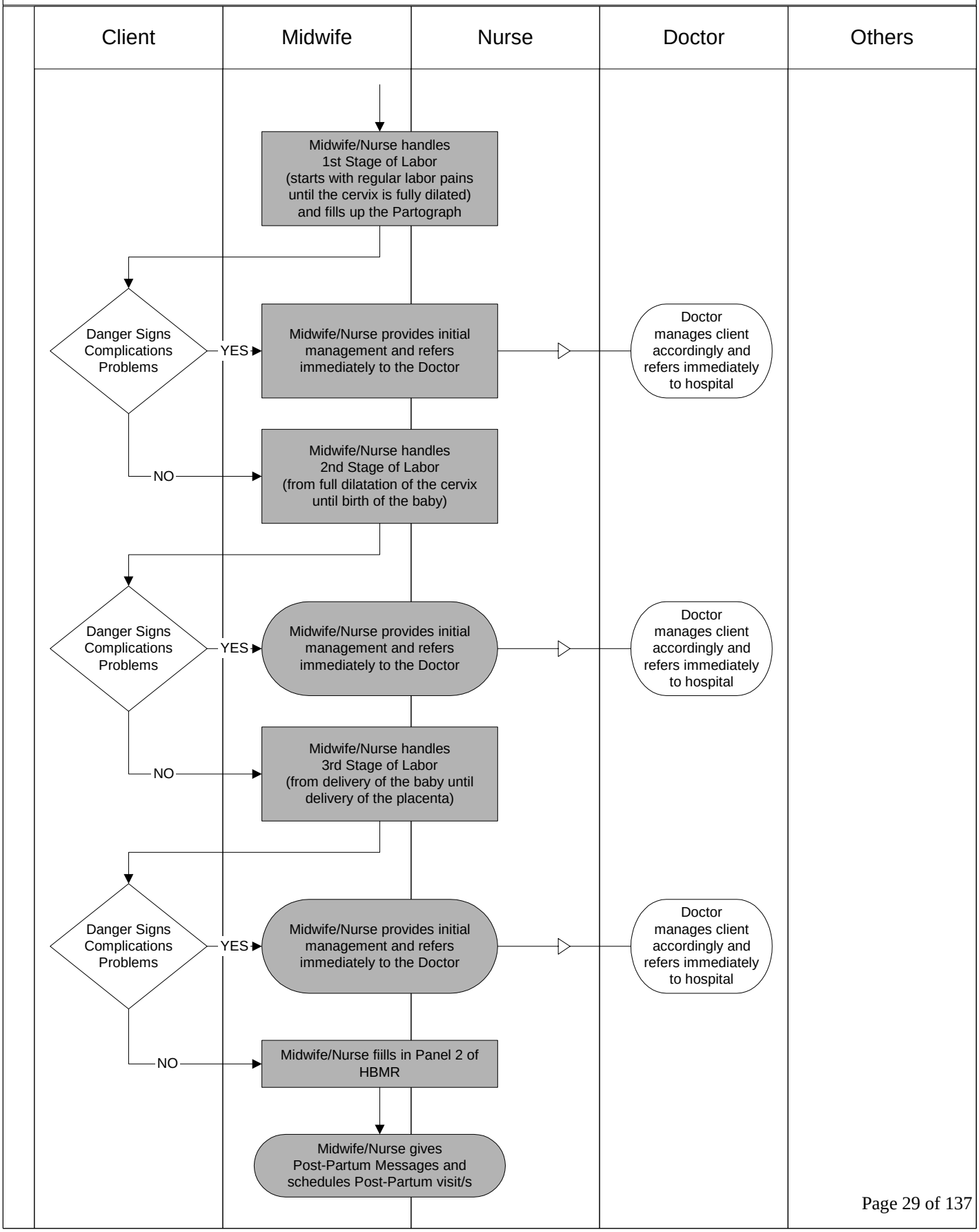
F. Midwife Provides Re-Echoes Counseling Messages and Validates Birth Plans	YES	NO	N/A
1. Does the midwife reinforce counseling messages on the Do's and Don't's in pregnancy?			
a. Warn her to refrain from smoking (whether active or passive) and from drinking alcoholic beverages.			
b. Warn her to avoid exposure to insecticides.			
c. Tell her to consult immediately for any complaints and not to resort to self-medication.			
d. Reassure her that it's alright to have sexual intercourse unless she has a history or preterm labor.			

2. Does the midwife reiterate the danger signs of pregnancy?	YES	NO	N/A
a. Profuse painless vaginal bleeding.			
b. Pallor.			
c. Watery vaginal discharge.			
d. Malpresentation.			
e. Headache, puffiness and edema.			
3. Does the midwife reinforce counseling messages on fertility awareness and family planning?			
4. Does the midwife reinforce counseling messages on breastfeeding?			
a. Practice the 3 E's			
• Early: mother should start right after delivery.			
• Exclusive: mother will feed her baby only on breast milk up to 6 months.			
• Extended: mother should continue for 2 years.			
b. Facts on breastfeeding			
• Breast milk alone is the best food for her baby in the first 6 months of life.			
o Giving other food or drink can be dangerous.			
o Breast milk helps to protect the baby against diarrhea and cough and colds.			
• Almost all mothers can produce enough milk for their baby if they:			
o Let the baby suck as often as he likes (on demand), day and night.			
o Use both breasts at each feeding.			
o Even if a woman has inverted nipples, she can breastfeed.			
• Bottle feeding may lead to serious illness and even death for the baby:			
o Bottle feeding can cause illness such as diarrhea if the water is not boiled and the nipple is not sterilized for each feeding.			
• Crying after breastfeeding is not a sign that a baby needs formula or other solutions. It normally means that the baby wants to be held and cuddled more. Some babies need to suck the breast simply for comfort.			
5. Does the midwife reinforce counseling messages on child care, parenting and responsible parenthood?			
6. Does the midwife counsel client on personal hygiene before and after delivery?			
7. Does the midwife validate the client's birth plans?			
a. Discuss with the client how she can get to the hospital if there is an emergency.			
b. Advise her to put aside some money in case of an emergency and for delivery.			
c. Discuss with her where she intends to deliver her baby.			
d. Tell her what to prepare for the delivery and for her baby.			

Program: Safe Motherhood
RHU Supervisory Flowchart: Natal (Labor and Delivery)



Program: Safe Motherhood
RHU Supervisory Flowchart : Natal (Labor and Delivery)



Safe Motherhood
RHU/HC Supervisory Checklist for Natal Care (Labor and Delivery)

A. Midwife Takes History of Labor	YES	NO	N/A
1. Does the midwife know what are the characteristics of true labor pains?			
a. The pain comes with regular intervals, which gradually becomes shorter.			
b. The pain gradually becomes more intense.			
c. There is discomfort in back and abdomen.			
d. There is gradual descent of the baby's head if cephalic.			
2. Does the midwife ask the client when the true labor pains begin?			
3. Does the midwife ask the client if the bag of water (BOW) has ruptured and when?			
4. Does the midwife ask the client if she has any of the Danger Sings of Pregnancy?			
a. Vaginal bleeding			
b. Headache, dizziness, blurred vision			
c. Puffiness of the face and hands			
d. Being pale or anemic			

B. Midwife Provides Initial Management and Refers Immediately to the Doctor	YES	NO	N/A
1. If in early labor, does the midwife refer the pregnant client with danger signs immediately to the Doctor?			
2. If she is in advanced labor (in other words, if she is fully dilated), does the midwife deliver the child of the pregnant woman with danger signs with extra cautiousness and prepare for hospital transport?			

C. Midwife Checks Client's HBMR	YES	NO	N/A
1. Does the midwife provide the pregnant client with an HBMR if she never had one and fills up the obstetrical history as shown in Panel 1 of the HBMR?			
2. Does the midwife check the obstetrical history of the pregnant client as shown in Panel 1 of the HBMR?			

D. Midwife Implements the 3 CLEANS	YES	NO	N/A
1. Does the midwife implement the 3 CLEANS?			
a. CLEAN HANDS			
i. You should have short fingernails.			
ii. Wash your hands with soap and water thoroughly and as frequently as necessary.			
iii. If possible, use sterile gloves.			
b. CLEAN DELIVERY SURFACE			
i. The delivery area, the bed, floor and its surroundings should be kept clean.			
ii. A clean linen which can easily be replaced when soiled is necessary if the mother delivers in supine.			
iii. The mother in early labor should be encouraged to take a full bath or wash herself from waist down and to wash her hands thoroughly with soap and water.			

c. CLEAN CUTTING AND CARE OF CORD	YES	NO	N/A
i. Instruments should be sterile.			

E. Midwife Examines the Client	YES	NO	N/A
1. Does the midwife check the pregnant client's blood pressure, temperature and pulse?			
2. Does the midwife check the pregnant client if has pallor?			
3. Does the midwife do an abdominal examination and check for the following:			
a. Fundic height			
b. Lie and presentation of the baby			
c. Level of the baby's head (is it engaged?)			
d. Fetal heart rate			
e. Frequency, duration and strength of the uterine contractions			
4. Does the midwife inspect the vulva for bleeding and amniotic fluid?			
5. Does the midwife know when an internal examination is indicated?			
a. NEVER if the woman has had vaginal bleeding after her 5th month of pregnancy.			
b. ONLY during labor.			
c. When the bag of water ruptures (to rule out cord prolapse).			
d. If malpresentation is suspected on abdominal examination.			
e. If there are no signs of full dilation after labor has lasted 6 hours in a multiparous and 12 hours in a primiparous.			
f. Before transferring a woman, to ensure she is not likely to deliver on the journey.			
g. In the 3rd stage, if there is postpartum hemorrhage, caused by retained placenta or suspected laceration.			
h. NEVER do an internal examination unless you have a good indication for doing so. Every internal examination may bring infection to the woman and her baby.			
6. Does the midwife do an internal examination if indicated?			
7. Does the midwife do an internal examination according to the following procedures:			
a. Explain to the woman what you are going to do. Tell her that it will be uncomfortable but that you will need her to relax, take slow, deep breaths and stay still.			
b. Take full aseptic precautions.			
c. Rinse the vulva with clean water.			
d. If possible, always wear sterile gloves.			
e. Inspect the vulva for:			
i. Amniotic fluid. If YES, is it clear or is it meconium stained?			
ii. Abnormal discharge such as blood or pus.			
f. Feel inside the vagina with the middle and index fingers and find out the following:			
iii. Cervical dilatation?			
iv. Cervical thickness?			
v. Is the bag of water intact or ruptured?			
vi. Is the amniotic fluid leaking? If so, what is the color?			

	YES	NO	N/A
vii. What is the presenting part?			
viii. Is the cord palpable? If so, what is the level of the presenting part?			

F. Midwife Handles the First Stage of Labor and Fills Up the Partograph	YES	NO	N/A
1. Does the midwife know that the first stage of labor begins with regular labor pains until the cervix is fully dilated?			
2. Does the midwife check that she has everything she needs for the delivery?			
3. Does the midwife explain to the mother what she is doing and why?			
4. Does the midwife encourage the mother to empty her bowels and bladder and to take a bath or wash from the waist down?			
5. Does the midwife explain to the mother that a full bladder may prolong the labor?			
6. Does the midwife encourage the mother to drink lots of fluids like buko?			
7. Does the midwife explain to the mother that fluids like buko will help her during labor because the contractions will make her thirsty and the sugar will give her energy for her labor?			
8. Does the midwife discourage the mother from taking solid food and explain that it may make her vomit?			
9. If the bag of water has not ruptured, does the midwife encourage the mother to walk about in early labor and empty her bladder frequently?			
10. Does the midwife make sure the mother does not bear down until the second stage of labor?			
11. Does the midwife make the following observations once every hour and record them:			
a. Blood pressure			
b. Temperature			
c. Character and frequency of uterine contractions			
d. Level of the baby's head on abdominal examination			
e. Fetal heart rate			
f. Inspection of vulva for amniotic fluid, bleeding or signs of second stage of labor			
12. Does the midwife write down the basic information in the first two lines of the partograph?			
13. Does the midwife start the partograph only when the woman is in labor and is contracting enough?			
14. Does the midwife take note that the first stage of labor is divided into two phases: the latent and active phase?			
a. Latent phase: contractions must be 1 or more in 10 minutes, each lasting 20 seconds or more.			
b. Active phase: contractions must be 2 or more in 10 minutes, each lasting 20 seconds or more.			
15. Does the midwife make key observations and recordings in the partograph?			
a. Progress of labor			
• Plotting of cervical dilatation			
• Plotting of Descent of Fetal head			
• Plotting of Uterine Contractions			
b. The Fetal Condition			
• Fetal heart rate			
• Membranes and amniotic fluid			

	YES	NO	N/A
• Molding of the fetal skull bone			
c. The Maternal Condition			
• Drugs, IV fluids and oxytocin given except analgesics			
• Pulse, blood pressure and temperature			
• Urine: volume, protein and acetone			

G. Midwife Provides Initial Management and Refers Immediately to the Doctor (clients with dangers signs/problems/complications during 1st stage of labor)	YES	NO	N/A
1. If in early labor, does the midwife refer the pregnant client with danger signs immediately to the Doctor?			
2. If she is in advanced labor (in other words, if she is fully dilated), does the midwife deliver the child of the pregnant woman with danger signs with extra cautiousness and prepare for hospital transport?			
3. Does the midwife consider the following as signs and symptoms of a transverse lie:			
a. The abdomen looks wider than usual.			
b. The poles of the baby are on each side and not at the top and the bottom.			
c. If the bag of water has ruptured, the arm or cord may be seen outside the vulva or felt on internal examination.			
4. Does the midwife refer the client with transverse lie presentation immediately to the doctor/hospital?			
5. Does the midwife advise the relative of the client with transverse lie presentation to accompany the patient to the hospital to donate blood as she is likely to need an operation?			
6. Does the midwife advise the client with transverse lie presentation and her relatives that if not treated immediately in the hospital, the baby will die and uterine rupture may occur?			
7. Does the midwife consider the following as signs and symptoms of breech presentation:			
a. The head, which is hard, is in the fundus and NOT at the lower end of the uterus.			
b. On internal examination, the soft buttocks or other small parts are felt.			
8. If in early labor and transport is available, does the midwife refer the client with breech presentation to the hospital for delivery?			
9. Does the midwife observe the following findings on internal examination for a brow or face presentation?			
a. In brow presentation, you will feel the anterior fontanelle, the supraorbital ridges and the base of the nose.			
b. In face presentation, you will feel the eyes, mouth, ears, nose and chin.			
10. If in early labor, does the midwife refer the client with brow/face presentation immediately to the doctor/hospital?			
11. If in advanced labor, does the midwife try to deliver the baby with brow/face presentation?			
12. If the baby is not delivered within 15 minutes, does the midwife refer the client with brow/face presentation immediately to the hospital?			
13. Does the midwife suspect a multifetal pregnancy if the following are present:			
a. Shape of the abdomen is not normal.			
b. Fundal height is more than 35 cm.			
c. Or there is more than 1 fetal outline.			
14. Does the midwife refer the client with multifetal pregnancy immediately to the doctor/hospital?			

	YES	NO	N/A
15. Does the midwife advise the client with multifetal pregnancy and her relatives that she should deliver in the hospital because she is more likely to have the following complications:			
a. Premature labor with low birth weight baby			
b. Malpresentation			
c. Prolapse of the cord			
d. Post partum hemorrhage			
16. Does the midwife refer the client immediately to the doctor/hospital if she suspects cephalopelvic disproportion (CPD) and the mother has been in labor without progress?			
17. Does the midwife advise the client with CPD and her relatives that if she is not taken to the hospital, the mother may die and the baby will be stillborn?			
18. Does the midwife consider prolonged labor when true labor lasts for more than 12 hours?			
19. Does the midwife consider the following as other signs and symptoms of prolonged labor that may or may not be present?			
a. Fever			
b. Bag of water has ruptured for a long time			
c. Maternal distress			
d. Fetal distress			
e. Swollen vulva			
f. Foul smelling vaginal discharge			
g. Meconium stained amniotic fluid			
h. Uterine contraction band or ring			
20. Does the midwife consider the following as possible causes of prolonged labor?			
a. Weak contractions			
b. Malpresentation: transverse lie, breech, brow or face presentation			
c. CPD			
d. Abnormalities of the birth canal			
e. Interlocking of twins in multifetal pregnancy			
21. Does the midwife treat shock if present in a client with prolonged labor?			
22. Does the midwife give Amoxycillin 1 gram PO to the client with prolonged labor?			
23. Does the midwife refer the client with prolonged labor immediately to the doctor/hospital?			
24. Does the midwife advise the client with prolonged labor and her relatives that the following may occur if the prolonged labor is not referred immediately?			
a. The mother and baby will get infected.			
b. The uterus may rupture particularly if the woman is a grand multipara.			
c. The woman may develop a hole (fistula) between the vagina and urinary bladder/rectum.			
d. The woman most probably will die and baby will be stillborn.			
25. Does the midwife consider the following as signs and symptoms of a threatened rupture of the uterus:			
a. The quality of the contractions is rapidly changing; the frequency, duration and strength are increasing. This may lead to continuous contractions without pause.			
b. The pain felt by the woman is increasing and becoming unbearable.			

c. The general condition of the woman is deteriorating rapidly.			
	YES	**NO**	**N/A**
d. Contraction band (ring) of the uterus may be seen even during uterine relaxation.			
e. Fetal distress.			
f. Urine may contain blood.			
26. Does the midwife give fluid replacement to the client with threatened rupture of the uterus?			
27. Does the midwife refer immediately to the doctor/hospital a client with threatened rupture of the uterus?			
28. Does the midwife advise the client with threatened rupture of the uterus and her relatives that only an immediate caesarian section can save her life?			
29. Does the midwife advise the relatives of the client with threatened rupture of the uterus that a relative or friend should go with her to donate blood?			
30. Does the midwife consider the following as signs and symptoms of a ruptured uterus:			
a. The strong labor pains have now stopped and the woman feels better for a short period of time.			
b. Her abdomen becomes irregularly shaped.			
c. Next she feels constant severe abdominal pain.			
d. Her general condition is rapidly worsening, shock develops within a few minutes.			
e. The fetus may be palpated immediately under the abdominal wall.			
f. The fetal heart beat is absent.			
g. There may be bleeding from the vagina.			
h. Urine may contain blood.			
31. Does the midwife give fluid replacement for a client with a ruptured uterus?			
32. Does the midwife give Amoxycillin 1 gram PO to a client with a ruptured uterus?			
33. Does the midwife refer immediately to the doctor/hospital a client with a ruptured uterus?			
34. Does the midwife advise the client with a ruptured uterus and her relatives that she needs an operation?			
35. Does the midwife advise the relatives of a client with a ruptured uterus to go with her to donate blood?			

H. Midwife Handles Second Stage of Labor	**YES**	**NO**	**N/A**
1. Does the midwife know that the second stage of labor starts from full dilatation of the cervix until the birth of the baby?			
2. Does the midwife tell that the client is already in the second stage of labor when:			
a. On internal examination, the cervix is fully dilated.			
b. The woman wants to bear down and feels that she needs to move her bowels.			
c. Uterine contractions come at intervals of 2 –3 minutes.			
d. During contractions, there is downward progress of the head, perineum and anus stretch and the bay's head becomes gradually visible at the opening of the vagina.			
e. The bag of water will rupture (if it has not already done so).			

3. Does the midwife follow the 12 steps in delivering the baby?	YES	NO	N/A
a. Implement the 3 CLEANS.			
b. Encourage the mother to bear down.			
c. The mother should try to stop bearing down when the baby's head is coming out. This gives her birth opening time to stretch. In order not to push, she should take many short rapid breaths.			
d. When the birth opening is stretching, support the perineum and anus with a clean swab to prevent lacerations. You may also use hot compresses.			
e. With the other hand, gently keep the head from coming out too quickly and try to keep it flexed (bent downward).			
f. Help the head to extend (bend upwards) as it comes out of the vulva, so that the perineum slides over the baby's face.			
g. Feel if the cord is around the baby's neck. If it is loose, slip it over the shoulders or head. If it is tight, place a finger under the cord and clamp it on both sides.			
h. As the baby's head comes out, wipe the baby's nose and mouth so that his airway is clear and he can cry.			
i. Wait for the external rotation: the head will turn sideways, bringing the shoulder into a good position: one shoulder wil be just below the symphysis and the other shoulder will face the perineum.			
j. Support the perineum with one hand and then gently pull the baby upwards so that the anterior shoulder comes under the symphysis pubis. Then pull the baby upwards so that the posterior shoulder slides over the perineum. Gently deliver the rest of the baby.			
k. Make sure the baby's airway is clear.			
l. After the cord has stopped beating, clamp it with 2 forceps 5 cms. Apart and cut between them. Do not clamp too close to the umbilicus (2.5 cms from the stump).			
m. Do the APGAR score.			
n. Dry, wrap and give the baby to his mother. Encourage her to start breastfeeding immediately. Do not remove all the vernix.			
4. Does the midwife do the ten basic steps of immediate newborn care?			
a. Remove mucus and fluid from the baby's mouth and nose with a piece of gauze, wrapped under around your finger, so that his airway is clear. If you have a rubber bulb syringe, use this but be very gentle.			
b. Do the APGAR score and repeat in 5 minutes.			
c. After the cord has stopped beating, clamp it with 2 forceps 5 cms. Apart, and cut between them with sterilized scissors or razor blade. But 2.5 cm from the stump.			
d. Tie the cord with sterilized thread or strips of cloth making a square knot or apply a special cord clamp. Dress the cord with alcohol, iodine or betadine poured straight from the bottle onto the cord. Leave it uncovered because this reduces the risk of infection.			
e. Keep the baby warm. Wipe and dry him but don't remove all the vernix since this helps protect him.			
f. Take the baby's weight.			
g. If the baby is crying, wrap him and give him to his mother. Advise her to start immediately. If the baby is not crying, stimulate him by rubbing the soles of his feet and resuscitate if necessary.			
h. Gently clean the baby's eyes with cold, boiled water and put tetracycline ophthalmic ointment in both eyes.			
i. Check that the baby is normal and has no congenital abnormalities.			
j. Take the baby's rectal temperature.			
5. Does the midwife fill out the Birth Certificate?			

6. Does the midwife resuscitate a newborn baby when necessary according to the following steps:	YES	NO	N/A
a. Keep the baby warm.			
b. Make sure the airway is clear: clean out mucus and amniotic fluid from mouth and nose with nasal bulb syringe if available or with clean gauze on your finger.			
c. Stimulate the baby by rubbing on his skin or gently tapping the soles of his feet. If he does not breathe, start mouth to mouth resuscitation.			
i. Extend the baby's head.			
ii. Cover the baby's nose and mouth entirely with your mouth.			
iii. Puff air into baby's lungs with cheek muscles only. You will see the baby's chest move. Let his lungs expand between puffs. Puff about 20 times in each minute.			
iv. Check if the heart is beating by feeling the chest and/or listening with a stethoscope.			
v. If the heart is not beating.			
1. Put your index and middle finger on the baby's sternum.			
2. Press down gently three times for each puff in mouth to mouth resuscitation.			
3. Stop when the baby starts to cry or breathe.			
4. Stop if the heart has not started beating in 10 minutes.			
7. Does the midwife fill out the Death Certificate and the E3 Form if the baby is stillborn?			

I. Midwife Provides Initial Management and Refers Immediately to the Doctor (clients with dangers signs/problems/complications during 2nd stage of labor)	YES	NO	N/A
1. Does the midwife provide initial management and refer immediately to the doctor/hospital mothers with danger signs, problems or complications?			
2. Does the midwife consider shoulder dystocia when the baby's head is born but the shoulders and body cannot be delivered?			
3. Does the midwife consider the following as warning signs of shoulder dystocia:			
a. There is delay in labor in a multiparous mother.			
b. The woman has a history of large babies and this baby feels big.			
c. Slow delivery of the head.			
d. The baby's head does not turn sideways.			
e. Moderate traction on the baby's head will not deliver the shoulders.			
4. Does the midwife conduct the following activities to deliver the baby with shoulder dystocia?			
a. Help the woman to move so that her buttocks are on the edge of the bed.			
b. Help her to bend (flex) her legs against her abdomen.			
c. Apply moderate traction to the baby's head while you count to 30.			
5. If the baby is still not delivered, does the midwife conduct the following activities to deliver the baby with shoulder dystocia?			
a. Ask the woman to turn onto her hands and knees with her bottom facing the midwife. This position will relax the pelvis and give room for applying traction to the baby's head. Be careful not to press on the baby's neck.			
b. Deliver the anterior (top) shoulder by gentle upward traction.			
c. Then deliver the posterior (bottom) shoulder by gentle downward traction.			

	YES	NO	N/A
6. If the baby is still not yet delivered, does the midwife refer immediately the client with shoulder dystocia to the hospital?			
7. Does the midwife refer immediately to the doctor/hospital delivered babies if:			
a. He remains blue despite resuscitation.			
b. His breathing is too fast (more than 60 per minute).			
c. His birth weight is less than 2,500 grams.			
d. There are severe congenital abnormalities present.			
e. The umbilicus is bleeding.			
8. Does the midwife follow the following in transferring/referring a baby:			
a. Mother should go with the baby.			
b. Keep the airway clear.			
c. Keep the baby warm but do not wrap too tightly.			
d. Send a referral letter with the following information:			
i. Time and date of birth			
ii. Reason for referral			
iii. Treatment already given to baby			

J. Midwife Handles Third Stage of Labor	YES	NO	N/A
1. Does the midwife know that the third stage of labor starts from the delivery of the baby until the delivery of the placenta?			
2. Does the midwife provide normal management of the third stage of labor?			
a. Wait for signs of placental separation.			
i. Fundus gets firmer and rises in abdomen.			
ii. Shape of the fundus changes.			
iii. Cord lengthens.			
iv. Small gush of blood from vagina.			
b. Do controlled traction.			
i. Put your left hand on abdomen below the fundus with palm facing mother's head.			
ii. Wind cord around your right hand.			
iii. Support the fundus firmly with your left hand while the cord is held in position. As the placenta reaches the perineum, slightly lift the cord.			
iv. Deliver the placenta slowly, holding it with both hands and rotating as you pull so that no pieces of the membrane are left behind.			
v. Massage fundus with left hand until it is hard.			
vi. Give the mother 1 Ergometrine tablet 0.125 mg.			
vii. Check if the placenta is complete.			
3. Does the midwife inspect perineum for lacerations?			

K. Midwife Provides Initial Management and Refers Immediately to the Doctor (clients with dangers signs/problems/complications during 3rd stage of labor)	YES	NO	N/A
1. Does the midwife refer the client immediately to the doctor/hospital if the placenta is not delivered within 1 hour after the baby has been born?			
2. Does the midwife treat every case of post partum hemorrhage first by the four basic actions?			
a. Massage the uterus.			
b. Give ergometrine 0.2 mg IM.			
c. Fluid replacement.			
d. Encourage the woman to pass urine. If she is unable to do so, catheterize. A full bladder prevents the uterus from contracting.			
3. Does the midwife consider retained placenta as probable cause of post partum hemorrhage if the following signs and symptoms are present:			
a. Placenta is not delivered 30 minutes after delivery of the baby.			
b. Controlled traction had failed.			
4. Does the midwife provide the following actions for client with probable retained placenta:			
a. If there is no hemorrhage:			
i. Do not try to deliver the placenta.			
ii. Refer the mother immediately to the doctor/hospital.			
b. If there is hemorrhage:			
i. If not trained to do manual removal of the placenta, refer mother immediately to the doctor/hospital.			
ii. If trained to do manual removal of the placenta, do the procedure.			
iii. If the above procedure fails, refer immediately to the doctor/hospital.			
5. Does the midwife consider retained placental fragments as probable cause of post partum hemorrhage if the following signs and symptoms are present:			
a. The placenta appears incomplete upon inspection.			
b. There is bleeding on the maternal surface of the placenta.			
c. The placenta is fragmented or cracked (torn) or there are torn blood vessels missing at the edge of the membranes.			
d. This may or may not be associated with bleeding.			
6. Does the midwife provide the following actions for client with probable retained placental fragments:			
a. If there is no hemorrhage:			
i. Do not try to deliver the placental fragments.			
ii. Refer the mother immediately to the doctor/hospital.			
b. If there is bleeding, give 20 units of oxytocin infused into 1 liter of D5 LRS or Normal Saline (or 10 units in 500 ml) at 60 drops per minute. If not available, use 10 units oxytocin IM.			
c. If trained to remove placental fragments manually, do the procedure.			
d. If not trained to remove placental fragments manually, refer mother immediately to the doctor/hospital.			
e. If the above procedure fails, refer immediately to the doctor/hospital.			
7. Does the midwife consider uterine atony as probable cause of post partum hemorrhage if the placenta has been delivered but the uterus remains soft or not well contracted?			

	YES	NO	N/A
8. Does the midwife provide the following actions for client with probable uterine atony:			
a. Give 20 units of oxytocin infused into 1 liter of D5 LRS or Normal Saline (or 10 units in 500 ml) at 60 drops per minute. If not available, use 10 units oxytocin IM.			
b. If the uterus is still soft, do external compression by pushing downward very carefully on the top of the uterus with one hand, while supporting the bottom of the uterus with the other hand.			
c. If the above procedure fails, refer immediately to the doctor/hospital.			
9. Does the midwife classify perineal lacerations according to the following:			
a. First degree: laceration is very shallow.			
b. Second degree: laceration goes into the muscle around the birth opening.			
c. Third degree: the muscle around the anus is torn.			
d. Fourth degree: laceration opens up the anus.			
10. Does the midwife determine if the perineal laceration needs to be sutured?			
a. First degree: this tear does not need to be sutured.			
b. Second degree: this will heal better if sutured.			
c. Third degree: do not try to suture, instead refer immediately to the doctor/hospital.			
d. Fourth degree: do not try to suture, instead refer immediately to the doctor/hospital.			
11. Does the midwife who is not trained to suture provide the following actions for client with perineal lacerations needing suturing:			
a. Place sterile pack high in vagina.			
b. Continue fluid replacement.			
c. Refer immediately to the doctor/hospital.			
12. Does the midwife who is trained to suture provide suturing to second degree perineal lacerations?			
a. Explain to the woman what you are going to do, that it will be uncomfortable, but that you need her to relax, take slow deep breaths and stay still.			
b. Give local anesthesia as follows:			
i. Clean the laceration with antiseptic solution.			
ii. Use a long needle and a big syringe (at least gauge 22 on a 10 ml syringe) to draw the anesthetic,1% lidocaine hydrochloride (or whatever is available). Be sure to clean off the top of the vial with alcohol before drawing up the anesthetic.			
iii. Be sure not to touch the needle; handle only the syringe.			
iv. Insert the needle at the top of the tear, just under the skin on one side. Insert the needle all the way, then aspirate the syringe to ensure that you are not in a blood vessel.			
v. If you are not in a blood vessel, inject the anesthetic as you slowly withdraw the needle.			
vi. Repeat this on the other side of the tear.			
vii. Wait for about 2 minutes before starting to suture.			
c. Insert pack into upper vagina.			
d. Suture in 3 layers, using adsorbable sutures like chromic catgut, dexon, etc. if no adsorbable suture is available, use cotton or silk on a curved needle and insert 1 or 2 stitches through all the layers; if possible, use a round and not a cutting needle.			

	YES	NO	N/A
e. Or suture the tissue as follows:			
i. Vaginal mucosa – starting 1 cm above the upper end of the laceration, do a continuous suture from above downwards.			
ii. Muscle – interrupted sutures.			
iii. Skin – interrupted sutures.			
f. Remove pack.			
g. Feel in rectum to make sure you have not put a stitch though it. If you have, remove it.			
13. Does the midwife determine acute inversion of the uterus when the placenta remains attached to the uterus and uterus turns "inside out"?			
14. Does the midwife consider the following as possible causes of acute inversion of the uterus:			
a. Grandmulitparas who previously had uterine atony.			
b. Strong cord traction before the placenta has separated.			
15. Does the midwife provide the following actions to a client with acute inversion of the uterus:			
a. Fluid replacement.			
b. Refer immediately to the doctor/hospital.			
c. Do not try to remove the placenta while the uterus is inverted.			
16. Does the midwife provide the following actions for a client with post partum hemorrhage with estimated blood loss of more than 500 ml:			
a. Give ORESOL if it will take more than an hour to reach the hospital.			
b. Make sure she is able to drink from a cup.			
c. Have her drink ORESOL as much as she can in small frequent sips and not in gulps as this will induce vomiting.			
d. As soon as the woman cannot drink from a cup or she starts vomiting, stop giving ORESOL as she might aspirate.			
e. Refer the woman if her condition needs referral.			
17. Does the midwife consider shock if the following signs and symptoms are present:			
a. Skin is cold, pale and clammy.			
b. Pulse is weak and rapid (over 120/minute).			
c. Systolic blood pressure is lower than 90 mm Hg.			
d. Restlessness.			
18. Does the midwife provide the following actions for a client in shock:			
a. Refer immediately to the doctor/hospital.			
b. Keep her warm, cover her with a blanket.			
c. Raise her hips higher than her head.			
d. Start IV fluids if available and if trained to do so.			
i. Use lactated ringers solution or normal saline solution.			
ii. Use needles that are no. 18 or 19. Do not use a very small needle.			
iii. Infuse as quickly as possible until the pulse is less than 100/minute and the systolic BP is 90-100 mm Hg. Then regulate the IV at 40 drops per minute.			
iv. Make sure that the bottle of fluid does not run out. Also make sure that the needle is well taped so that it stays in the vein and cannot move. You may need to splint the extremity to which the IV is attached.			

	YES	NO	N/A
v. Continue to monitor the pulse rate and BP and adjust fluid infusion whenever necessary.			
e. Look for the cause of shock and treat accordingly.			
f. If IV fluids not available:			
i. Give ORESOL if it will take more than an hour to reach the hospital.			
ii. Make sure she is able to drink from a cup.			
iii. Have her drink ORESOL as much as she can in small frequent sips and not in gulps as this will induce vomiting.			
iv. As soon as the woman cannot drink from a cup or she starts vomiting, stop giving ORESOL as she might aspirate.			

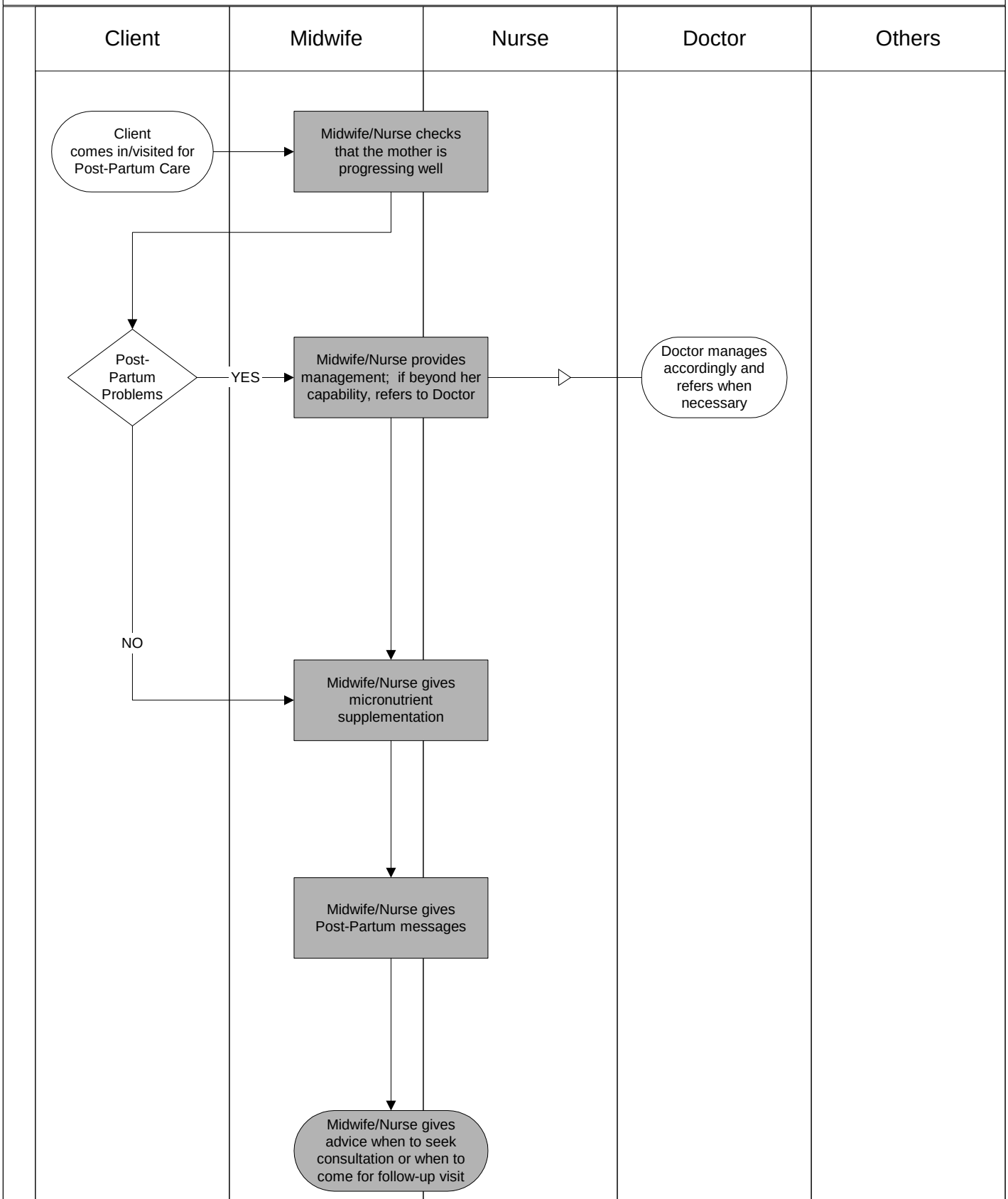
L. Midwife Fills In Panel 2 of the HBMR	YES	NO	N/A
1. Does the midwife fill in the sections in Panel 2 of the HBMR about labor and delivery?			
a. Immediate breatfeeding.			
b. Type of delivery.			
c. Place of delivery.			
d. Birth weight in grams.			
e. Post partum hemorrhage 500 ml+.			
f. Baby alive.			
g. Baby healthy.			

M. Midwife Gives Post-Partum Messages and Schedules Post-Partum Visits	YES	NO	N/A
1. Does the midwife provide the following post partum messages:			
a. Exclusive breastfeeding			
i. Why should a mother breasfeed immediately			
• She is more likely to breastfeed for a long time.			
• If she delays even for just a few hours, breastfeeding is more likely to fail.			
• The time right after birth is a good time to teach a baby to suck because the sucking reflex is strong.			
• Breastfeeding helps the uterus to contract and reduces bleeding.			
• Sucking on the breast immediately after birth helps create a stronger bond between mother and baby.			
b. Family Planning			
i. Benefits			
• It saves mother's and children's lives.			
• It is a way for a woman to delay pregnancy until she is ready and to have her babies at the healthiest time in her life.			
• It helps her to space birth so that her body can recover from her previous delivery.			
• It helps her to avoid getting pregnant again after a high risk pregnancy.			
• It allows a family to stop having babies when they have had the number of children that is right for them.			

	YES	NO	N/A
• It prevents unwanted pregnancies and abortions.			
ii. Risks of another pregnancy too soon			
• If mother has had too many pregnancies (more than 4) and/or a birth interval of less than 2 years, she is more likely to have complications during pregnancy and labor.			
• The baby is more likely to be small and sickly.			
iii. Most suitable FP methods for a mother who is breastfeeding:			
• IUD			
• Progesterone only pill			
• Condom			
• Natural family planning (NFP)			
• Spermicides			
• Permanent methods (BTL and vasectomy)			
c. Hygiene			
i. Wash hands with soap and water before washing her perineum.			
ii. Use sanitary napkins or clean (ironed) cloth as “sapin” (pads).			
iii. Take a bath or at least sponge bath, daily.			
iv. Wash the perineum every time she passes urine or stool with plain, preferably pre-boiled water, or guava leaf decoction and soap. Instruct her to wash from the front of the vagina to behind the anus.			
d. Routine baby care			
i. Warmth			
• Newborn babies get cold very easily particularly if they are of low birth weight.			
• Wrap the baby in a blanket but the best way for a baby to keep warm is for him to have skin to skin contact with his mother.			
• Do not use hot water bottles.			
ii. Hygiene			
• Always wash hands carefully with soap before handling the baby.			
• Clean all equipment you use for the baby. If possible, use separate equipment for the baby.			
• The mother should sponge-bath the baby every day until the cord falls off, then give him a full bath. If you give him a full bath before the cord comes off, be sure to dry the cord and umbilicus carefully afterwards.			
• Wash and iron the baby’s clothes and linen. Keep them in a clean place.			
iii. Care of the Cord			
• Leave uncovered and keep dry. Infection of the baby’s cord is less likely if it is left uncovered.			
• Do not put anything on the cord (such as ashes, oil and powder).			
• Advise the mother to bring the child to the hospital at once if the cord smells bad or the umbilicus is red.			
• Explain that the cord comes off spontaneously at 7 to 10 days and should not be pulled off.			

	YES	NO	N/A
• Explain about the signs of neonatal tetanus, which are:			
o Failure to suck (this is the most important sign)			
o Foul smelling discharge on cord			
o Feels hot when touched			
o Convulsions (a late sign)			
2. Does the midwife advise the client when to seek consultation or come for scheduled visits?			
a. If with signs and symptoms for the following:			
i. Fever of 38 C and above			
ii. Foul smelling vaginal discharge			
iii. Excessive bleeding			
iv. Pallor			
b. Post partum visits			
c. Immunization schedule for mother and infant			
d. Sick child			
i. Baby does not suck and may be very sleepy.			
ii. Jaundice within 24 hours after delivery or which he does not better within10 days.			
iii. Cord is foul smelling and umbilicus is red.			
iv. Other signs such as vomiting, high pitched cry, abnormal breathing and convulsions.			

Program: Safe Motherhood
RHU Supervisory Flowchart: Post-Partum Visit



Safe Motherhood
RHU/HC Supervisory Checklist for Post Partum Visit

A. Midwife Checks that Mother is Progressing Well	YES	NO	N/A
1. Does the midwife define normal postpartum period as the period starting from the end of labor until the genital tract has returned to normal (usually 6 to 8 weeks)?			
2. Does the midwife check if the mother is progressing well during postpartum visits?			

B. Midwife Provides Management (postpartum problems); If Beyond Her Capability, Refers to Doctor	YES	NO	N/A
1. Does the midwife consider the following as signs and symptoms of postpartum breast problems?			
a. Infection (Mastitis and Breast Abscess)			
i. Part of one breast is red and painful.			
ii. The mother may have fever.			
b. Sore or cracked nipples			
i. Pain, redness and/or rough surface on nipples or area surrounding nipples.			
c. Engorgement			
i. Both breasts are painful and appear tense and shiny.			
2. Does the midwife consider the following as causes of postpartum breast problems?			
a. Infection (Mastitis and Breast Abscess)			
i. Infection may follow engorgement or cracked nipples if these are not treated. Onset is one week or more after delivery.			
b. Sore or cracked nipples			
i. Poor positioning and attachment.			
c. Engorgement			
i. Partly due to milk and partly to blood and fluid filling the breasts.			
d. Insufficient milk			
i. Insufficient sucking			
ii. Giving fluids other than breast milk			
iii. Wrong feeding position/attachment			
3. Does the midwife provide the following actions for postpartum breast problems?			
a. Infection (Mastitis and Breast Abscess)			
i. Advise rest and application of compresses on affected breast.			
ii. Encourage her to continue breastfeeding on both breasts.			
iii. Give her Amoxycillin 500 mg TID.			
iv. Give her Paracetamol 500 mg for pain and fever.			
v. See her again in 2 days.			
1. If she is not better, refer her to the doctor.			
2. If she is better, have her complete a 5 day course of antibiotics.			
vi. Follow-up after treatment to ensure continued breastfeeding and help her to build up milk supply again if necessary.			

	YES	NO	N/A
vii. Breast abscess will require referral to doctor for incision and drainage.			
b. Sore or cracked nipples			
i. Advise the mother to do the following:			
1. Wash nipples with clean water once a day. Avoid using soaps, creams or sprays.			
2. Correct the feeding position and continue to breastfeed.			
3. Wear loose cotton clothes. Do not wear a bra.			
4. Leave a drop of milk on the nipples after feeding to help the skin to heal.			
5. If she cannot breastfeed, express milk manually.			
c. Engorgement			
i. Advise the mother to do the following:			
1. Let the baby continue sucking if possible. Make sure the feeding position is correct.			
2. If baby cannot suck, express the milk manually.			
3. Stimulate ejection reflex by putting compresses on the breast or by gently massaging the skin around the nipple.			
d. Insufficient milk			
i. Advise the mother to do the following:			
1. Exclusive breastfeeding.			
2. Correct the feeding position and continue to breastfeed on both breasts.			
3. Breastfeed whenever the baby is hungry.			
4. Breastfeed at night.			
5. Express milk manually whenever she has to leave the house.			
4. Does the midwife consider postpartum fever when client develops a temperature of 39C or more within 14 days of delivery?			
5. Does the midwife identify associated signs and symptoms of postpartum fever, its probable causes and render appropriate management?			
a. Foul smelling vaginal discharge			
i. Probable cause: Uterine Infection			
ii. Actions:			
1. If abdomen is painful when touched (even when touched very lightly), refer immediately to doctor/hospital.			
2. If abdomen is not painful when touched, give Amoxicillin 500 mg TID for 7 days.			
3. See her again after 2 days. If she is not better, refer to doctor.			
b. Frequent or painful urination			
i. Probable cause: Urinary Tract Infection			
ii. Actions			
1. Advise her to drink lots of fluids.			
2. Give Amoxycillin 500 mg TID for 7 days.			
3. If no improvement in 2 days, refer to doctor.			

	YES	NO	N/A
c. Indications of malaria			
i. Probable cause: Malaria			
ii. Actions			
1. Give her Chloroquine tablets (Day 1: 4 tablets, followed by 2 tablets 6 hours later).			
2. See her the next day.			
a. If better, continue treatment for Day 2: 2 tablets and Day 3: 2 tablets.			
b. If not better, refer to doctor.			
d. No other symptoms are present.			
i. Probable cause: Unknown			
ii. Actions: Refer to the doctor.			
6. Does the midwife consider the following as signs and symptoms of postpartum depression?			
a. Mother feels sad.			
b. Mother is not interested in baby.			
7. Does the midwife manage postpartum depression by doing the following:			
a. Talk to the mother and listen to what she has to say.			
b. Encourage her to tell you what she feels and reassure her.			
c. Explain to the family that she is likely to recover but they must help her with taking care of the baby and keeping the house until she recovers.			
8. Does the midwife manage postpartum clients with inability to pass urine accordingly?			
a. Encourage the mother to pass urine spontaneously by flushing water and by putting alternate hot and cold compresses on her lower abdomen.			
b. If this fails, catheterize.			
c. If she is still unable to pass urine, refer to doctor/hospital.			
9. Does the midwife consider the following as signs and symptoms of a fistula:			
a. Woman has no control over urination and/or bowel movements.			
b. Urine and/or fecal matter leaks out of her vagina continuously or intermittently.			
10. Does the midwife refer the client with fistula to the doctor for further evaluation and management?			

C. Midwife Provides Micronutrient Supplementation	YES	NO	N/A
1. Does the midwife provide the mother with one capsule of Vitamin A 200,000 IU immediately after delivery or within a month?			
2. Does the midwife provide the mother 2 tablets of Iron/Folate (60 mg elemental iron plus 0.25 mg folic acid) daily for 2 months and longer if she has pallor?			

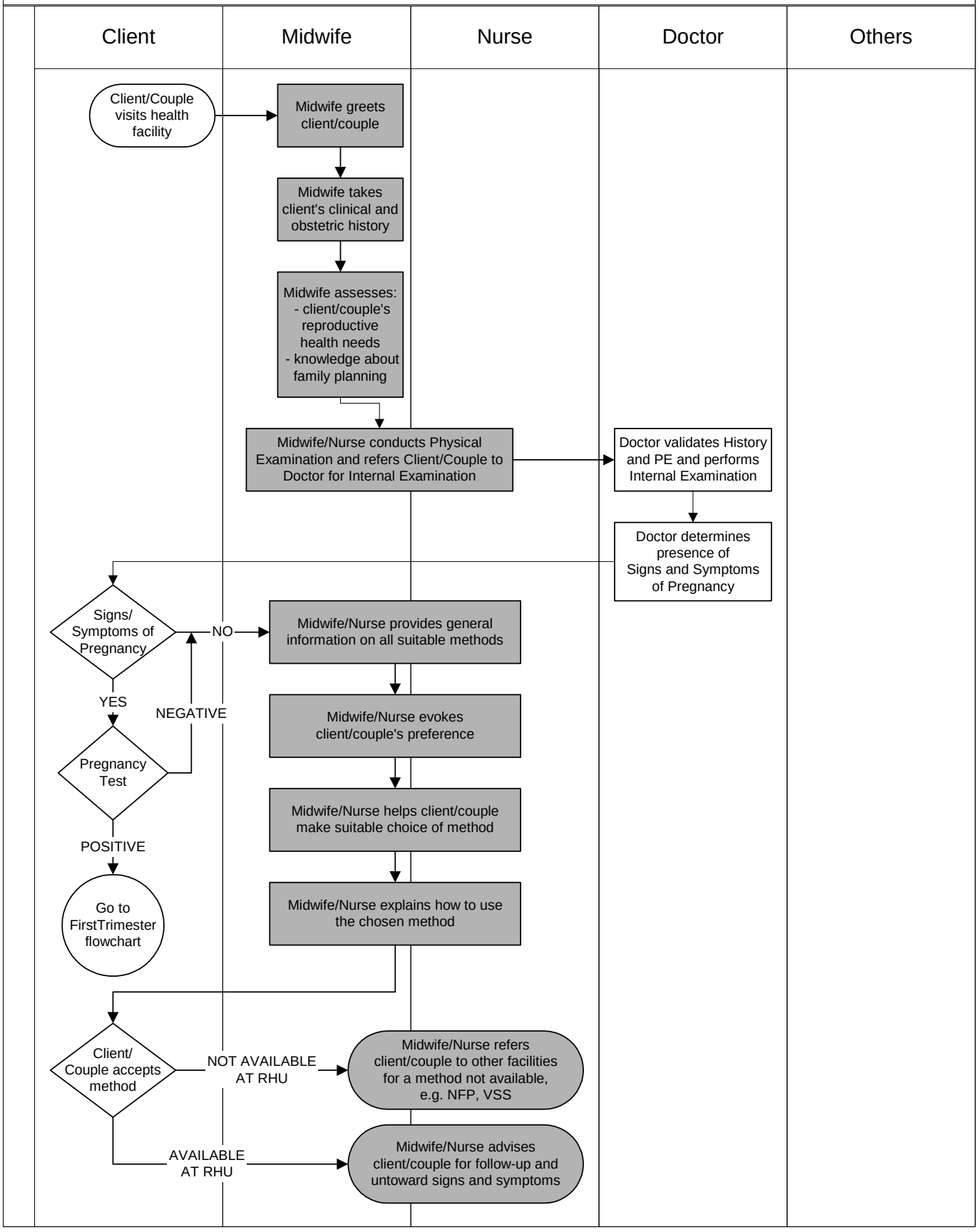
D. Midwife Gives Postpartum Messages	YES	NO	N/A
1. Does the midwife provide the following post partum messages:			
a. Exclusive breastfeeding			
i. Why should a mother breasfeed immediately			
• She is more likely to breastfeed for a long time.			

	YES	NO	N/A
• If she delays even for just a few hours, breastfeeding is more likely to fail.			
• The time right after birth is a good time to teach a baby to suck because the sucking reflex is strong.			
• Breastfeeding helps the uterus to contract and reduces bleeding.			
• Sucking on the breast immediately after birth helps create a stronger bond between mother and baby.			
b. Family Planning			
i. Benefits			
• It saves mother's and children's lives.			
• It is a way for a woman to delay pregnancy until she is ready and to have her babies at the healthiest time in her life.			
• It helps her to space birth so that her body can recover from her previous delivery.			
• It helps her to avoid getting pregnant again after a high risk pregnancy.			
• It allows a family to stop having babies when they have had the number of children that is right for them.			
• It prevents unwanted pregnancies and abortions.			
ii. Risks of another pregnancy too soon			
• If mother has had too many pregnancies (more than 4) and/or a birth interval of less than 2 years, she is more likely to have complications during pregnancy and labor.			
• The baby is more likely to be small and sickly.			
iii. Most suitable FP methods for a mother who is breastfeeding:			
• IUD			
• Progesterone only pill			
• Condom			
• Natural family planning (NFP)			
• Spermicides			
• Permanent methods (BTL and vasectomy)			
c. Hygiene			
i. Wash hands with soap and water before washing her perineum.			
ii. Use sanitary napkins or clean (ironed) cloth as "sapin" (pads).			
iii. Take a bath or at least sponge bath, daily.			
iv. Wash the perineum every time she passes urine or stool with plain, preferably pre-boiled water, or guava leaf decoction and soap. Instruct her to wash from the front of the vagina to behind the anus.			
d. Routine baby care			
i. Warmth			
• Newborn babies get cold very easily particularly if they are of low birth weight.			
• Wrap the baby in a blanket but the best way for a baby to keep warm is for him to have skin to skin contact with his mother.			
• Do not use hot water bottles.			

ii. Hygiene	YES	NO	N/A
• Always wash hands carefully with soap before handling the baby.			
• Clean all equipment you use for the baby. If possible, use separate equipment for the baby.			
• The mother should sponge-bath the baby every day until the cord falls off, then give him a full bath. If you give him a full bath before the cord comes off, be sure to dry the cord and umbilicus carefully afterwards.			
• Wash and iron the baby's clothes and linen. Keep them in a clean place.			
iii. Care of the Cord			
• Leave uncovered and keep dry. Infection of the baby's cord is less likely if it is left uncovered.			
• Do not put anything on the cord (such as ashes, oil and powder).			
• Advise the mother to bring the child to the hospital at once if the cord smells bad or the umbilicus is red.			
• Explain that the cord comes off spontaneously at 7 to 10 days and should not be pulled off.			
• Explain about the signs of neonatal tetanus, which are:			
o Failure to suck (this is the most important sign)			
o Foul smelling discharge on cord			
o Feels hot when touched			
o Convulsions (a late sign)			

E. Midwife Gives Advice When to Seek Consultation or When to Come for Follow-Up Visit	YES	NO	N/A
1. Does the midwife advise the client when to seek consultation or come for scheduled visits?			
a. If with signs and symptoms for the following:			
i. Fever of 38 C and above			
ii. Foul smelling vaginal discharge			
iii. Excessive bleeding			
iv. Pallor			
b. Post partum visits			
c. Immunization schedule for mother and infant			

Family Planning
RHU Supervisory Flowchart: Initial Visit



Family Planning
Supervisory Checklist

I. Initial Visit

A. Midwife Greets Client/Couple	YES	NO	N/A
1. Does the midwife greet the client/couple warmly?			

B. Midwife Takes Client's Clinical and Obstetric History	YES	NO	N/A
1. Does the midwife use the Client Record Form or FP Form 1?			
2. Does the midwife ask for the following information when taking the clinical history of the client?			
b. Name, Age and Marital Status			
c. History of Family Planning utilization			
d. Basic Medical Information (e.g. past medical history, family medical history, history of allergy; ask client about disease condition starting from head to foot)			
e. History of smoking, alcohol and drug use			
3. Does the midwife ask for the following information when taking the client's obstetric history?			
a. Number of pregnancies			
b. Number of births, premature deliveries			
c. Number of living children			
d. Number of abortion			
e. Last Menstrual Period (LMP)			
f. Past Menstrual Period (PMP)			

C. Midwife Assesses Client/Couple's Reproductive Health Needs and Knowledge About Family Planning	YES	NO	N/A
1. Does the midwife assess the client/couple's reproductive health needs by asking for the following:			
a. Desired family size			
b. Desire to space or limit pregnancy			
c. If opts for spacing, ask whether long term (more than 3 years) or short term (3 years)			
2. Does the midwife ask the client/couple what family planning method he/she knows?			

D. Midwife Conducts Physical Examination and Refers Clients/Couples to Doctor for Internal Examination	YES	NO	N/A
1. Does the midwife include the following regions of the body as part of the complete physical examination during the initial visit and every year thereafter?			
a. Head and Neck			
b. Chest – heart, lungs, breast examination			
c. Abdomen – tenderness, rigidity, palpable mass			
d. Genitalia – lesion, warts, vaginal discharge			

e. Internal examination – refer to the Doctor			
f. Extremities – presence of varicosities			
	YES	**NO**	**N/A**
2. Does the midwife refer clients/couples to the doctor for internal examination?			

E. Client has Signs and Symptoms of Pregnancy	**YES**	**NO**	**N/A**
1. Does the midwife perform pregnancy test on the client if she has signs and symptoms of pregnancy?			
2. Does the midwife refer for prenatal care clients who test positive for pregnancy?			

F. Midwife Provides General Information on All Suitable Methods	**YES**	**NO**	**N/A**
1. Does the midwife give general information on all methods to the client/couple?			
a. What method it is			
b. Advantages and disadvantages			
c. Side effects			
d. Correction of rumors and misconceptions			

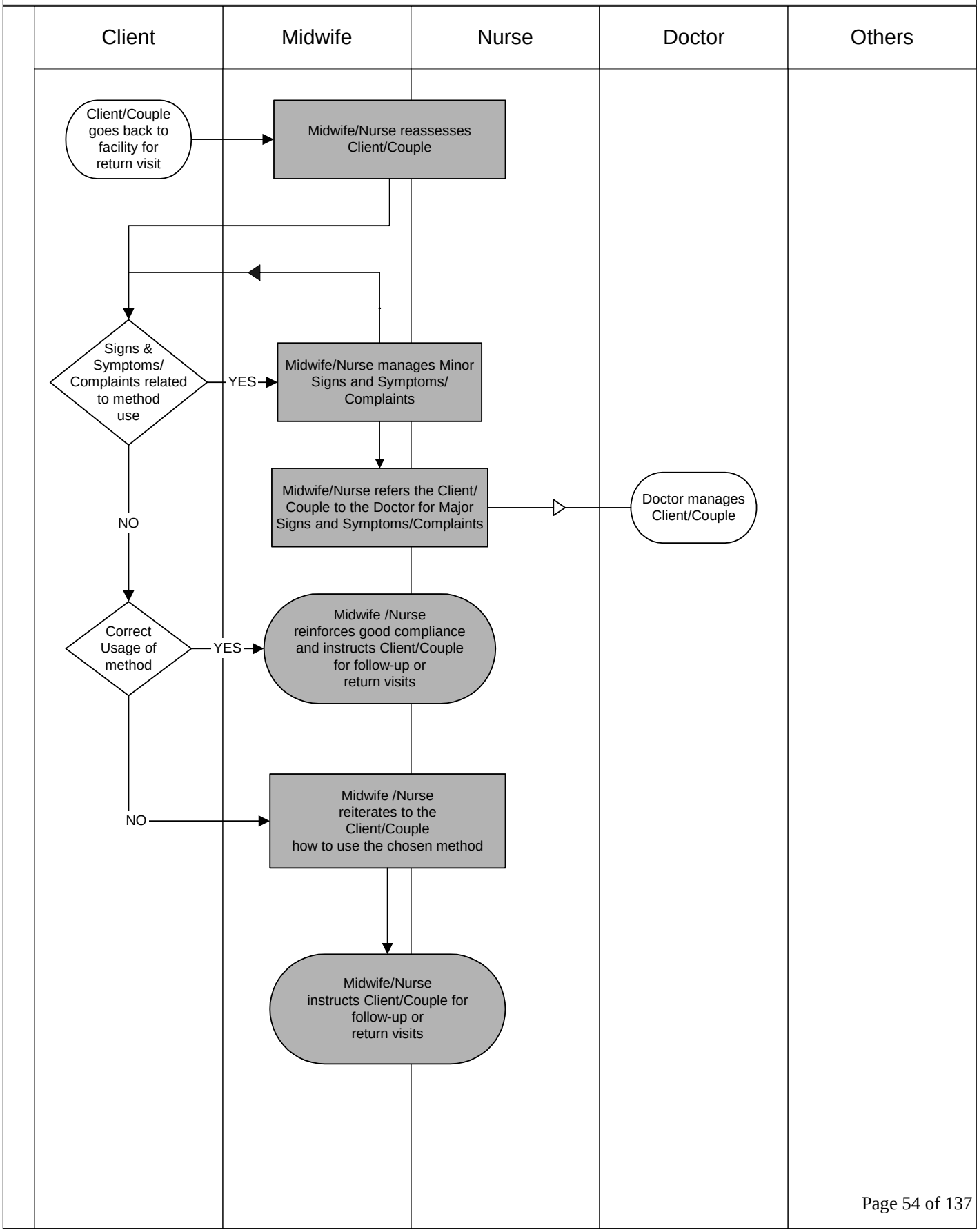
G. Midwife Evokes Client/Couple's Preference and Helps Them Choose a Method	**YES**	**NO**	**N/A**
1. Does the midwife ask the client/couple which method he/she prefers and help them choose a method? (Match the reproductive needs and preferences with a FP method)			
a. Ask client / couple which method they prefer - check if method preferred is appropriate to the client.			
b. If appropriate, health staff reiterates advantages, disadvantages, potential side effects and correct rumors/misconceptions of method being considered.			
c. If not appropriate, tell the client the reasons why and help the client choose another method.			

H. Midwife Explains How To Use The Chosen Method	**YES**	**NO**	**N/A**
1. Does the midwife explain clearly how to use the chosen method?			
a. Give detailed steps on proper use of the chosen method.			
b. Describe the warning signs, side effects, complications and what to do if they have it.			
c. Ask client to repeat information in her own words to confirm clients / couples' understanding.			
d. Tell the client when to return to clinic for follow up and for any side effects and complication of the method used.			

I. Midwife Refers Client/Couple to Other Facilities for Services Not Available at the RHU	**YES**	**NO**	**N/A**
1. Does the midwife refer the client/couple to other health facilities for FP services not offered at the RHU/HC?			

J. Midwife Advises Client/Couple for Follow-Up and Untoward Signs and Symptoms	**YES**	**NO**	**N/A**
1. Does the midwife advise the client/couple when to return for follow-up and in the event of untoward signs and symptoms?			

Family Planning
RHU Supervisory Flowchart for Return Visits



Family Planning
Supervisory Checklist

II. Return Visit

A. Midwife Reassesses Client/Couple	YES	NO	N/A
1. Does the midwife ask the client/couple if they are satisfied with the method they are using?			
2. Does the midwife re-assess signs and symptoms and correct usage of the method?			

B. Midwife Manages Minor Signs and Symptoms/Complaints	YES	NO	N/A
1. Does the midwife identify and manage minor signs and symptoms/complaints?			

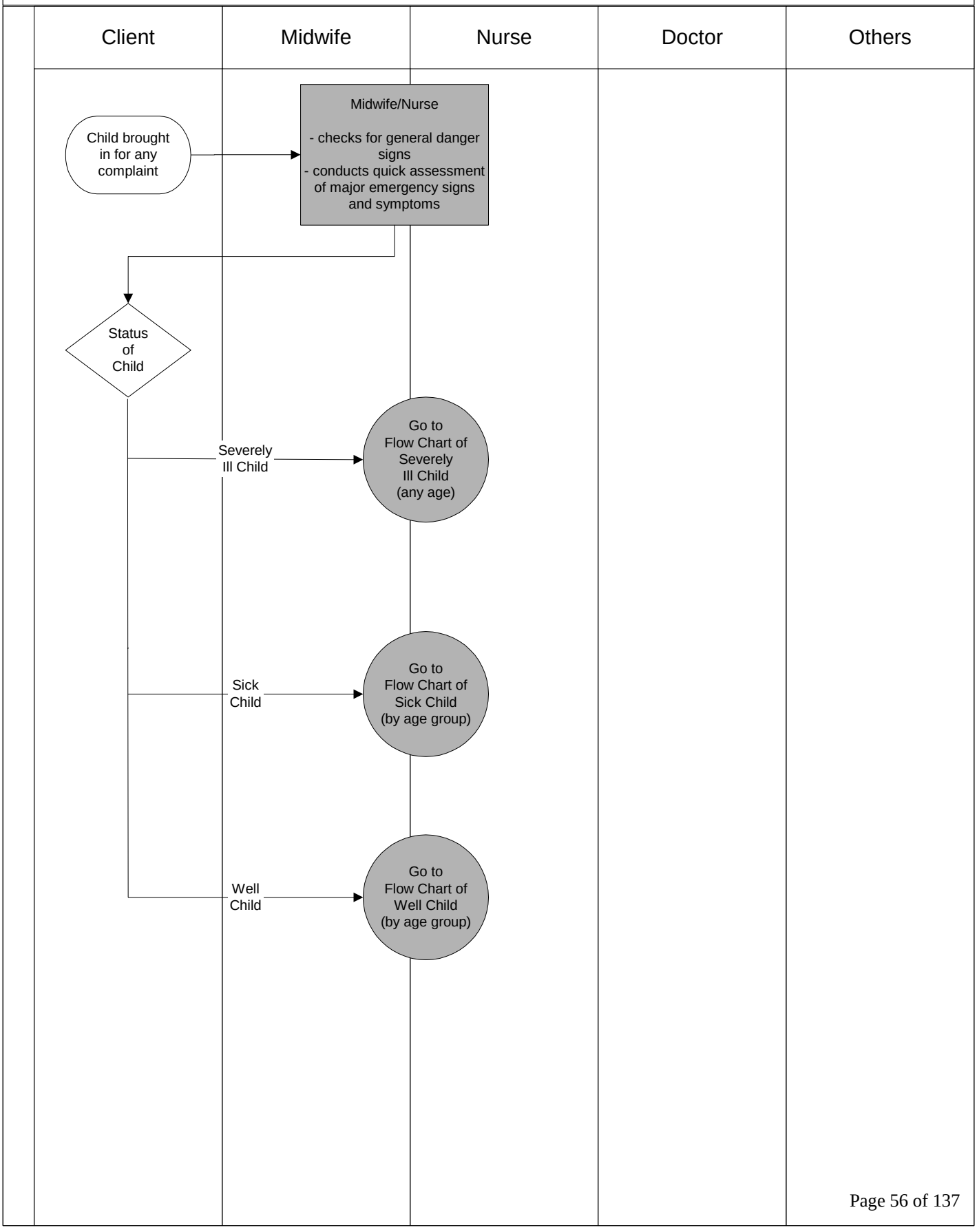
C. Midwife Refers the Client/Couple to the Doctor for Major Signs and Symptoms/Complaints	YES	NO	N/A
1. Does the midwife refer the client/couple to the Doctor for Major Signs and Symptoms/Complaints?			

D. Midwife Reinforces Good Compliance and Instructs Client/Couple for Follow-Up or Return Visits	YES	NO	N/A
1. Does the midwife reinforce the client's/couple's good compliance to chosen method?			
2. Does the midwife instruct the client/couple when to return for follow-up visits?			

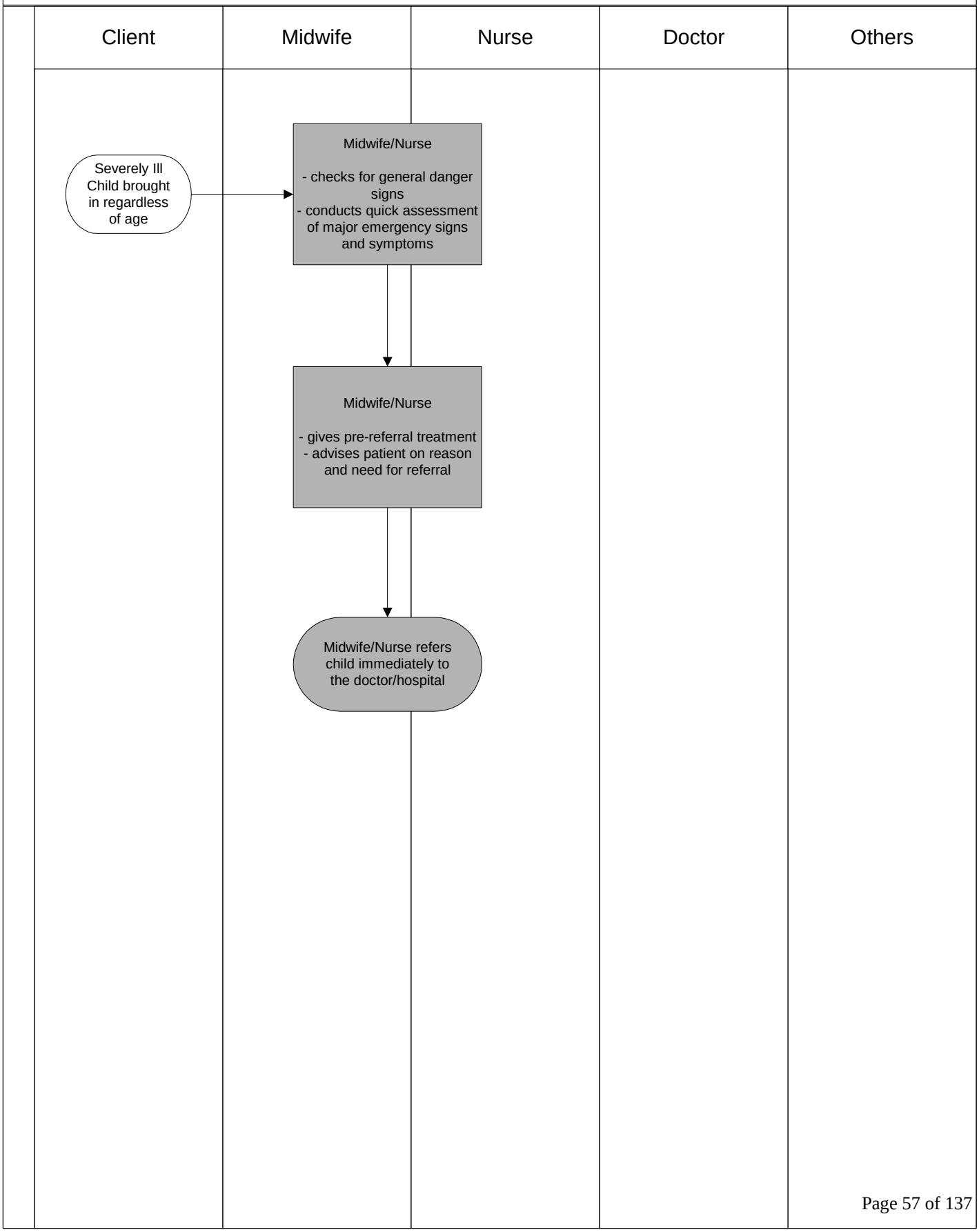
E. Midwife Reiterates to the Couple How to Use the Chosen Method	YES	NO	N/A
1. Does the midwife reiterate to the client/couple how to properly use the chosen method?			

F. Midwife Instructs Client/Couple for Follow-Up/Return Visits	YES	NO	N/A
1. Does the midwife instruct the client/couple when to come back for follow-up or return visits?			

Child Care
RHU Supervisory Flow Chart : Overview



Child Care
RHU Supervisory Flow Chart for Severely Ill Child



Child Care
Supervisory Checklist

I. OVERVIEW

A. Midwife Conducts Quick Assessment	YES	NO	N/A
1. Does the midwife do quick assessment for every child brought in the clinic by doing the following:			
a. Asks for chief complaints/reasons for clinic visit?			
b. Takes vital signs and weight?			
c. Checks for general danger signs?			
d. Classifies child according to the three categories (severely ill, sick or well child)?			

II. SEVERELY ILL CHILD

A. Midwife Checks for General Danger Signs	YES	NO	N/A
1. Does the midwife ask about general danger signs to include the following:			
a. Unable to drink or breastfeed			
b. Vomits everything			
c. Has had convulsions			
d. Abnormally sleepy or lethargic or difficult to awaken			

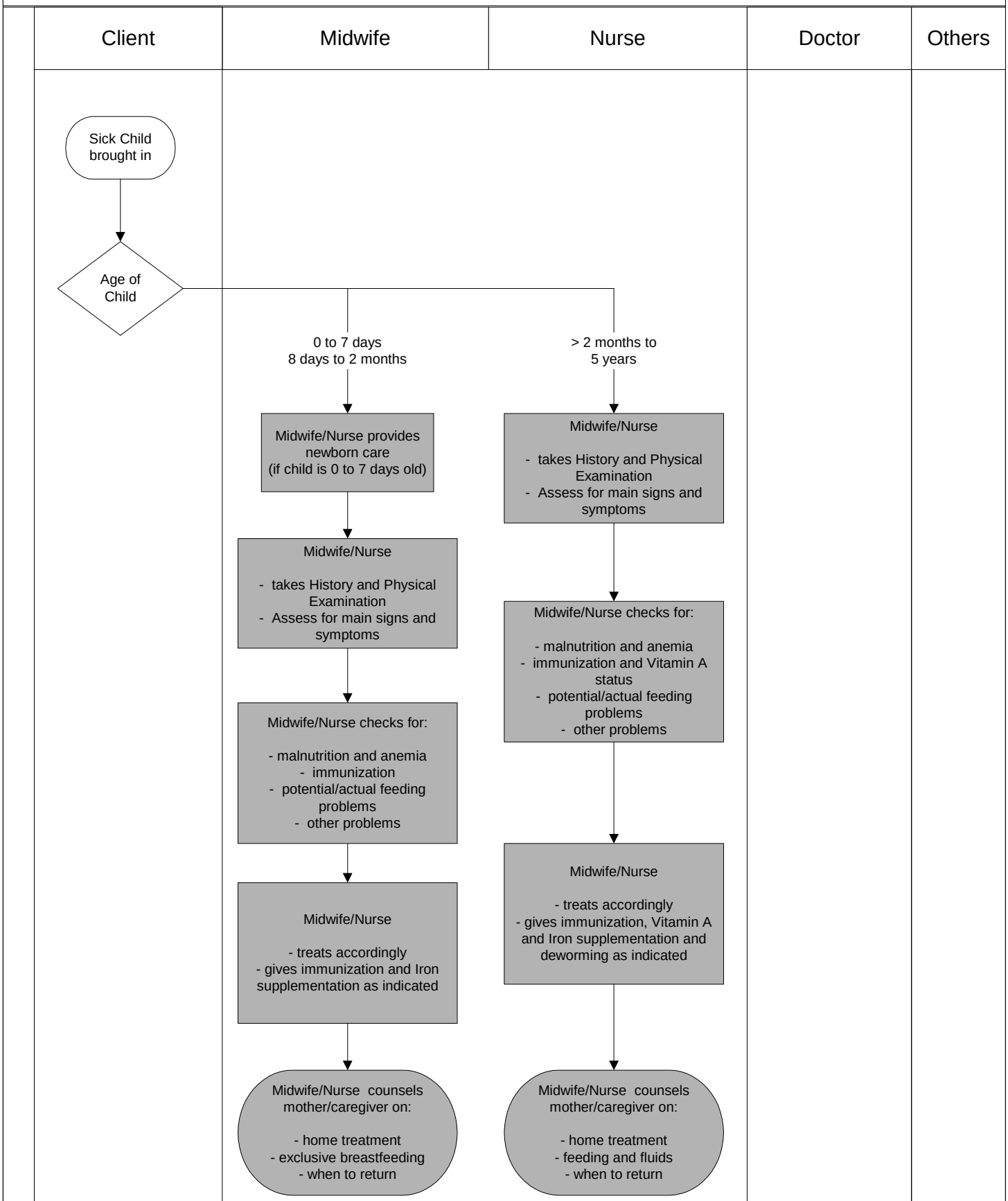
B. Midwife Conducts Quick Assessment of Major Emergency Signs and Symptoms	YES	NO	N/A
1. If positive for danger signs, does the midwife do quick assessment for major signs and symptoms?			
a. Cough or difficult breathing			
b. Diarrhea			
c. Fever			
d. Ear Problem			

C. Midwife Gives Pre-Referral Treatment	YES	NO	N/A
1. Does the midwife give pre-referral treatment (e.g. 1st dose antibiotic, ORS, Paracetamol, etc) before referral?			

D. Midwife Advises Patient on Reason and Need for Referral	YES	NO	N/A
1. Does the midwife advice caregiver on the reason, need, and importance of immediate referral?			

E. Midwife Refers Child Immediately to the Doctor/Hospital	YES	NO	N/A
1. Does the midwife facilitate transport of referred clients?			

Child Care
RHU Supervisory Flow Chart for Sick Child



III. SICK CHILD

Sick Child 0 to 7 days and 8 days to 2 months old

A. Midwife Provides Newborn Care	YES	NO	N/A
1. Does the midwife provide newborn care to children 0 to 7 days old?			

B. Midwife Takes History and Physical Examination and Assesses for Main Signs and Symptoms	YES	NO	N/A
1. Does the midwife check for possible serious bacterial infection by doing the following:			
a. Asks if the infant had convulsions			
b. Counts the breaths in one minute (60 breaths per minute or more)			
c. Looks for severe chest indrawing			
d. Looks for nasal flaring			
e. Looks and listens for grunting			
f. Looks and feels for bulging fontanel			
g. Looks for pus draining from the ear			
h. Measures temperature (38.5°C & above or below 35.5°C)			
i. Looks for skin pustules (many or severe)			
j. See if the young infant is abnormally sleepy or difficult to awaken			
2. Does the midwife refer the infant immediately if positive for any of the signs above?			
3. Does the midwife ask for diarrhea?			
4. Does the midwife classify as local bacterial infection if:			
a. Red umbilicus or draining pus			
b. Skin pustules			

C. Midwife Checks for Malnutrition and Anemia; Midwife Checks for Potential/Actual Feeding Problems	YES	NO	N/A
1. Does the midwife determine the infant's weight for age?			
2. Does the midwife observe breastfeeding and check for the following:			
a. Infant's chin is touching mother's breast			
b. Infant's mouth is wide open			
c. Infant's lower lip is turned outward			
d. More areola is visible above than below the mouth of the infant			
e. Infant is suckling effectively			
2. Does the midwife check for feeding problems or low weight by asking for the following:			
a. Difficulty in feeding?			
b. If breastfed, how many times?			
c. Food/drinks aside from breastfeeding?			

	YES	NO	N/A
d. What is used to feed the child?			

D. Midwife Checks for Immunization and Other Problems	YES	NO	N/A
1. Does the midwife check the infant's immunization status?			
2. Does the midwife assess for other problems?			

E. Midwife Treats Accordingly; Midwife Gives Immunization and Iron Supplementation as Indicated	YES	NO	N/A
1. Does the midwife treat the infant according to DOH protocols?			
2. Does the midwife give the appropriate antibiotic for bacterial infections?			
3. Does the midwife treat local infections in the clinic?			
4. Does the midwife manage infants with diarrhea according to protocol?			

F. Midwife Counsels Mother/Caregiver on Home Treatment, Exclusive Breastfeeding and When to Return	YES	NO	N/A
1. Does the midwife teach the mother/caregiver how to treat local infections and corresponding home care?			
2. Does the midwife advise the mother/caregiver on home care and proper feeding if with breastfeeding/feeding problem and low weight?			
3. Does the midwife advise the mother/caregiver when to return for follow-up?			

Sick Child >2 months to 5 years

A. Midwife Takes History and Physical Examination and Assesses for Main Signs and Symptoms

1. Acute Respiratory Infection	YES	NO	N/A
a. Does the midwife assess for cough or difficult breathing by doing the following:			
i. Asking for duration of cough or difficult breathing?			
ii. Counting the respiratory rate per minute?			
iii. Looking for chest indrawing?			
iv. Listening for stridor?			
b. Does the midwife classify the child appropriately according to the following:			
i. As having severe pneumonia if with any of the general danger signs or chest indrawing or stridor in a calm child?			
ii. As having pneumonia if with fast breathing?			
iii. As having cough or cold no pneumonia if there are no signs?			
c. Does the midwife assess the child for Tuberculosis if with cough for 14 days or more?			

2. Diarrhea	YES	NO	N/A
a. Does the midwife assess for diarrhea by doing the following:			
i. Asking for how long was the diarrhea?			
ii. Asking if there is blood in the stool?			
iii. Looking at the general condition?			
iv. Checking if the child is abnormally sleepy or difficult to awaken?			
v. Checking if the child is restless or irritable?			
vi. Looking for sunken eyes?			
b. Does the midwife assess the response of the child with diarrhea when offered fluids by observing the following:			
i. Is the child able to drink or is drinking poorly?			
ii. Is the child drinking eagerly or thirsty?			
c. Does the midwife assess skin turgor of the child with diarrhea by pinching the skin of the abdomen and observing if it goes back slowly or very slowly, longer than 2 seconds?			
d. Does the midwife classify the child with diarrhea as having severe dehydration if any of the following 2 signs are present: i. Abnormally sleepy or difficult to awaken ii. Sunken eyes iii. Not able to drink or drinks poorly iv. Skin pinch goes back very slowly			
e. Does the midwife classify the child with diarrhea as having some dehydration if any two of the following signs are present: i. Restless and irritable ii. Sunken eyes iii. Drinks eagerly, thirsty iv. Skin pinch goes back slowly			

	YES	NO	N/A
f. Does the midwife classify the child with diarrhea as no dehydration if there are no enough signs to classify as having some or severe dehydration?			
g. Does the midwife classify the child with diarrhea as having persistent diarrhea if duration is for 14 days or more?			
h. Does the midwife classify the child with diarrhea as having dysentery if there is blood in the stool?			

3. Fever (Malaria)	YES	NO	N/A
a. Does the midwife assess if the child with fever has malaria risk by doing the following:			
i. Asking whether living in a malaria area or visited a malaria area in the past 4 weeks?			
ii. Obtaining a malarial smear?			
b. Does the midwife elicit pertinent information on the child's fever by asking for the following:			
i. For how long the fever was?			
ii. If fever has been for more than 7 days, has it been present every day?			
iii. Has the child had measles within the last 3 months?			
c. Does the midwife look and feel for a stiff neck? Does the staff look for a runny nose?			
d. Does the midwife classify the child with very severe disease for malaria if:			
i. With any general danger sign or ii. With stiff neck			
e. Does the midwife classify the child as having malaria if he/she has a positive malarial smear?			

4. Fever (Measles)	YES	NO	N/A
a. Does the midwife look for signs of measles such as:			
i. Generalized rashes?			
ii. One of these: cough, runny nose, or red eyes?			
b. Does the midwife look for the following if a child has measles now or within the last 3 months:			
i. Mouth ulcers and whether it is deep and extensive?			
ii. Pus draining from the eyes?			
iii. Clouding of the cornea?			
c. Does the midwife classify the child with measles according to the following:			
i. As severe complicated measles when there is clouding of the cornea and/or deep and extensive mouth ulcers?			
ii. As measles with eye or mouth complications when there is pus draining from the eye and/or mouth ulcers?			
iii. As measles now or within the last 3 months?			

5. Fever (Dengue Fever)	YES	NO	N/A
a. Does the midwife assess dengue risk by asking for the following:			
i. Any bleeding from nose, gums, vomitus or stools?			
ii. Black vomitus?			
iii. Black stool?			
iv. Abdominal pain?			
v. Vomiting?			
b. Does the midwife look and feel for:			
i. Bleeding from the nose and gums?			
ii. Skin petechiae?			
iii. Cold and clammy extremities?			
iv. Check for capillary refill			
c. Does the midwife perform the tourniquet test if none of the above ASK or LOOK and FEEL signs are present and the child is 6 months or older and fever present for more than 3 days?			
d. Does the midwife classify the child with fever according to the following:			
i. As severe dengue hemorrhagic fever if there are: • Evidence of bleeding: bleeding from nose and gums, blood in vomitus or stools, black stools or vomitus, skin petechiae? • Cold and clammy extremities? • Capillary refill of more than 3 seconds or more? • Abdominal pain or vomiting? • Positive tourniquet test?			
ii. As fever, dengue hemorrhagic fever unlikely if there are no signs of severe dengue hemorrhagic fever?			

6. Ear Problem	YES	NO	N/A
a. Does the midwife ask the caregiver if the child has ear pain?			
b. Does the midwife ask the caregiver if there is pus draining from the ear of the child? If so, for how long?			
c. Does the midwife look for pus draining from the ear or for a red, immobile eardrum (by otoscopy)?			
d. Does the midwife palpate for tender swelling behind the ear?			
e. Does the midwife classify the ear problem according to the following:			
i. As acute ear infection if there is pus draining from the ear less than two weeks or presence of a red, immobile ear drum (by otoscopy)?			
ii. As chronic ear infection if with pus draining from the ear for two weeks or more?			
iii. As mastoiditis if there is tender swelling behind the ear?			

B. Midwife Checks for Malnutrition and Anemia; Midwife Checks for Potential/Actual Feeding Problems	YES	NO	N/A
1. Does the midwife assess nutritional status by looking and feeling for the following:			
a. Visible severe wasting			
b. Edema of both feet			

	YES	NO	N/A
c. Palmar pallor			
2. Does the midwife determine the child's weight for age?			
3. Does the midwife check for feeding problems or low weight by asking for the following:			
a. Difficulty in feeding?			
b. If breastfed, how many times?			
c. Food/drinks aside from breastfeeding?			
d. What is used to feed the child?			

C. Midwife Checks for Immunization, Vitamin A Status and Other Problems	YES	NO	N/A
1. Does the midwife check the child's immunization status?			
2. Does the midwife check for the child's Vitamin A status?			
3. Does the midwife assess for other problems?			

D. Midwife Treats Accordingly

1. Acute Respiratory Infection	YES	NO	N/A
a. Does the midwife treat the child with cough or difficult breathing according to the following DOH protocols:			
i. Refers immediately if with severe pneumonia?			
ii. If with Pneumonia			
• Gives antibiotic (Cotrimoxazole)?			
• Gives 1st dose antibiotic before sending the child home?			
• Advises on how to treat the child at home?			
• Advises when to return the child immediately?			
• Advises the mother/caregiver to bring the child for follow up in 2 days?			
iii. If with cough or cold, no pneumonia			
• Advises safe home remedy to relieve cough?			
• Advises safe home remedy to soothe the throat?			
• Advises the mother/caregiver to bring child immediately for follow-up if he/she becomes sicker, develops fever or not able to drink or breastfeed, develops fast breathing or difficult breathing?			

2. Diarrhea	YES	NO	N/A
a. Does the midwife refer immediately severely dehydrated children to the hospital for intravenous fluid therapy?			
b. Does the midwife give frequent sips of ORS on the way to a severely dehydrated child referred to the hospital?			

c. Does the midwife manage children with some dehydration by:	YES	NO	N/A
i. Giving ORS at the health facility?			
ii. Giving two packs of ORS to take home?			
iii. Giving advice on:			
• Continued feeding?			
• How to give ORS at home?			
• When to return?			
d. Does the midwife manage children with no dehydration by:			
i. Giving advice on:			
• Home fluids?			
• Continued feeding?			
• When to return?			
ii. Giving two packets of ORS to take home?			
e. Does the midwife manage children with persistent diarrhea by:			
i. Giving Vitamin A?			
ii. Giving advice on:			
• How to feed the child?			
• Follow up in 5 days?			
f. Does the midwife refer the child immediately if with persistent diarrhea with dehydration?			
g. Does the midwife give Vitamin A before referring the child with persistent diarrhea with dehydration?			

3. Fever (Malaria)	YES	NO	N/A
a. Does the midwife treat the child with malaria according to the following:			
i. With oral anti-malarial?			
ii. With one dose of Paracetamol at the health center?			
b. Does the midwife give pre-referral treatment (1st dose antibiotic, paracetamol, sugar water) prior to referring the child to the hospital?			
c. Does the midwife advice the mother/caregiver when to return immediately and to follow up in 2 days if fever persists?			
d. Does the midwife refer the child to doctor if still with fever for more than 7 days?			

4. Fever (Measles)	YES	NO	N/A
a. Does the midwife treats the child with measles according to protocol:			
i. If with severe complicated measles:			
• Gives Vitamin A?			
• Gives 1st dose of antibiotics (Cotrimoxazole)?			
• Applies Tetracycline ophthalmic ointment if with clouding of the cornea or pus draining from the eyes?			

	YES	NO	N/A
• Refers immediately to hospital?			
ii. If with mouth or eye complications:	**YES**	**NO**	**N/A**
• Gives Vitamin A?			
• Applies Tetracycline ophthalmic ointment if with pus draining from the eye?			
• Teaches mother to treat mouth ulcers with Gentian violet?			
• Advises follow-up in 2 days?			
b. Does the midwife give Vitamin A if the child has measles now or within the last 3 months?			

5. Fever (Dengue Fever)	YES	NO	N/A
a. Does the midwife treat the child according to DHF protocol?			
i. If with severe dengue hemorrhagic fever:			
• Refers the child immediately to the hospital?			
• Does not give aspirin?			
• Gives ORS to the child on the way to the hospital?			
ii. If fever only no dengue hemorrhagic fever:			
• Advises mother when to return immediately?			
• Advises follow up in 2 days if fever persists?			
• Does not give aspirin?			

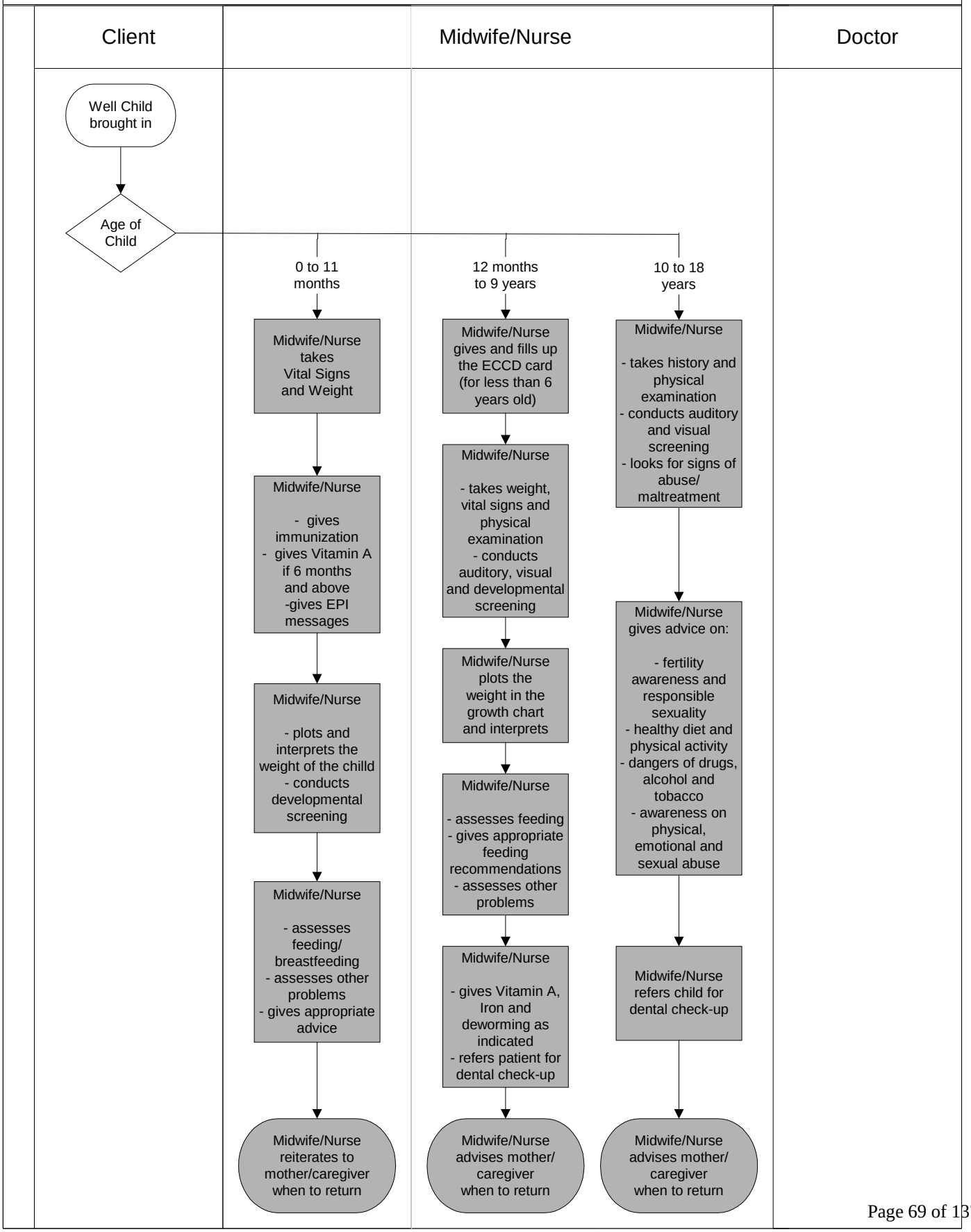
6. Ear Problem	YES	NO	N/A
a. Does the midwife manage children with acute ear infection by:			
i. Giving Cotrimoxazole for 5 days?			
ii. Drying the ear by wicking?			
iii. Reassessing in 5 days?			
iv. Treating fever with paracetamol?			
b. Does the midwife manage children with chronic ear infection by:			
i. Drying the ear by wicking?			
ii. Treating fever with paracetamol?			
c. Does the midwife manage children with mastoiditis by:			
i. Referring urgently to the hospital?			
ii. Treating with paracetamol if with fever or pain (not aspirin)?			

E. Midwife Gives Immunization, Vitamin A and Iron Supplementation and Deworming as Indicated	YES	NO	N/A
1. Does the midwife provide immunization when indicated?			
2. Does the midwife provide iron supplementation and deworming when indicated?			

3. Does the midwife give Vitamin A capsule to a sick child with:	YES	NO	N/A
a. Measles			
b. Severe pneumonia			
c. Persistent diarrhea			
d. Severe and moderate malnutrition			
e. Anemia			

F. Midwife Counsels Mother/Caregiver on Home Treatment, Feeding and Fluids and When to Return	YES	NO	N/A
1. Does the midwife provide the key messages for a sick child such as:			
a. How to treat at home?			
b. Feeding a sick child?			
c. When to return immediately?			
d. When to come back for follow-up?			

Child Care
RHU Supervisory Flow Chart for Well Child (0 to 18 years old)



IV. WELL CHILD

0 to 11 months old

A. Midwife Takes Vital Signs and Weight	YES	NO	N/A
1. Does the midwife take the vital signs the infant?			
2. Does the midwife weigh the child properly?			
a. Undresses the child or leaves as little clothes as possible.			
b. Sets weighing scale at 0 before weighing the child.			

B. Midwife Gives Immunization; Gives Vitamin A and Gives EPI Messages	YES	NO	N/A
1. Does the midwife immunize infants according to schedule?			
a. BCG immediately after birth			
b. DPT1, OPV1 at 6 weeks			
c. DPT2, OPV2 at 10 weeks			
d. DPT3, OPV3 at 14 weeks			
e. AMV at 9 months			
2. Does the midwife give the correct antigen for age and schedule, correct dose and correct route of administration?			
a. Administers BCG, 0.05 ml to infants below 6 weeks old.			
b. Gives the vaccine intradermally on the deltoid area using tuberculin syringe (producing a flat wheal with surface pitted like orange peel appear at injection site).			
c. Administers DPT/Hep B to infants 6 weeks – 11 months old in 3 doses at 4 weeks interval.			
d. Gives DPT/Hep B 0.5 ml intramuscular at the upper outer portion of the thigh (gives each dose of vaccine on each thigh).			
e. Administers OPV to infants 6 weeks – 11 months old in 3 doses at 4 weeks interval.			
f. Gives OPV, 2 drops orally.			
g. Administers AMV to infants 9 – 11 months.			
h. Gives AMV 0.5 ml subcutaneous on the deltoid area of the upper arm.			
3. Does the midwife observe aseptic technique in handling vaccines?			
a. Health worker washes hand with soap and water before vaccination.			
b. Vaccination area and table where vaccines are placed is clean.			
c. Uses one syringe/needle per child per antigen.			
d. Cleans the injection site with cotton ball moistened with water and let skin dry.			
e. Is careful not to let needle touch dirty surfaces.			

4. Does the midwife handle vaccines properly during vaccination session?			
a. Vaccine protected from sunlight.			
b. Vaccine kept cold in vaccine carrier with ice.			
c. Vaccine not immersed in water.			
d. Vaccine vial monitor reading still potent.			
e. Vaccines used not expired.			
f. Reconstituted BCG and AMV discarded after immunization session or after 6 hours.			
5. Does the midwife give Vitamin A supplementation to children given AMV vaccination?			
6. Does the midwife advise mothers of the following:			
a. Importance/benefits of immunization, such as protection against illnesses and increased body resistance?			
b. Possible side reactions, such as fever and rash, pain/soreness on injection site?			
c. When to return for the next dose?			

C. Midwife Plots and Interprets the Weight of the Child	YES	NO	N/A
1. Does the midwife plot the weight on the growth chart, interpret it and explain the weight and growth status of the child?			

D. Midwife Conducts Developmental Screening	YES	NO	N/A
1. Does the midwife assess developmental milestones using the ECCD checklist?			

E. Midwife Assesses Feeding/Breastfeeding, Assesses Other Problems and Gives Appropriates Advice	YES	NO	N/A
1. Does the midwife assess feeding when there is growth faltering (declining line on the growth chart) or plotted weight below the lower line of the growth chart by asking the following:			
a. Is child breastfeeding?			
b. If yes, how many times during the day and at night?			
c. What complementary foods are given?			
d. How many times per day?			
e. Does child receive adequate servings?			
f. Has own bowl and spoon?			
2. Does the midwife assess other problems and gives appropriate advice?			
3. Does the midwife instruct the mother/caregiver how to feed the child based on the feeding recommendation on the ECCD card?			

F. Midwife Reiterates to Mother/Caregiver When to Return	YES	NO	N/A
1. Does the midwife reiterate to mother/caregiver when to return immediately or for follow-up?			

IV. WELL CHILD

12 months to 9 years old

A. Midwife Gives and Fills Up the ECCD Card (for children less than 6 years old)	YES	NO	N/A
1. Does the midwife issue and fill up the ECCD Card for children less than 6 years old?			

B. Midwife Takes Weight, Vital Signs and Physical Examination	YES	NO	N/A
1. Does the midwife get the child's temperature, cardiac rate, respiratory rate, weight and height?			
2. Does the midwife examine the child from head to toe?			

C. Midwife Conducts Auditory, Visual and Developmental Screening	YES	NO	N/A
1. Does the midwife conduct auditory and visual screening?			
2. Does the midwife assess developmental milestones using the ECCD checklist?			

D. Midwife Plots the Weight in the Growth Chart and Interprets	YES	NO	N/A
1. Does the midwife plot the weight on the growth chart, interpret it and explain the weight and growth status of the child?			

E. Midwife Assesses Feeding, Gives Appropriate Feeding Recommendations and Assesses Other Problems	YES	NO	N/A
1. Does the midwife assess feeding when there is growth faltering (declining line on the growth chart) or plotted weight below the lower line of the growth chart by asking the following:			
a. Is child breastfeeding?			
b. If yes, how many times during the day and at night?			
c. What complementary foods are given?			
d. How many times per day?			
e. Does child receive adequate servings?			
f. Has own bowl and spoon?			
2. Does the midwife give appropriate feeding recommendations?			
3. Does the midwife assess other problems?			

F. Midwife Gives Vitamin A, Iron and Deworming as Indicated	YES	NO	N/A
1. Does the midwife give Vitamin A to a child 6 months old and above and has not received Vitamin A for the past 6 months?			
2. Does the midwife give Vitamin A correctly?			
a. If child is 12 months and above, cut across the nipple of the capsule and squirt the Vitamin A into the child's open mouth.			
b. If child is below 12 months, 3 drops of Vitamin A.			
3. Does the midwife give iron and deworming as indicated?			

G. Midwife Refers Child for Dental Check-Up	YES	NO	N/A
1. Does the midwife refer the child for dental check up as needed (child is at least 2-3 years old and check up every 6 months)?			
2. Does the midwife advise on proper tooth brushing?			

H. Midwife Advises Mother/Caregiver When to Return	YES	NO	N/A
1. Does the midwife advise the mother/caregiver when to return to the RHU/HC?			

IV. WELL CHILD

10 to 18 years old

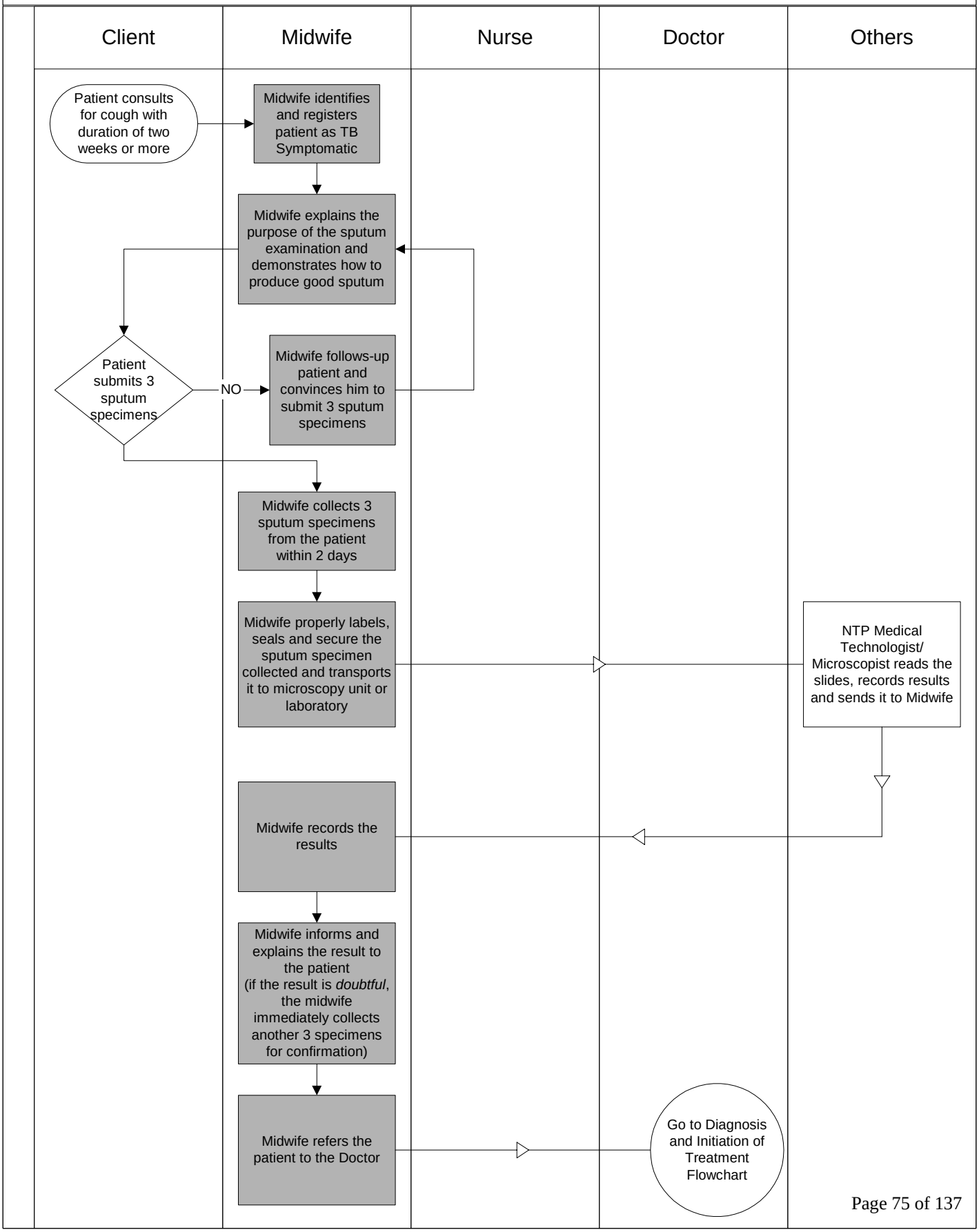
A. Midwife Takes History and Physical Examination, Conducts Auditory and Visual Screening and Looks for Signs of Abuse/Maltreatment	YES	NO	N/A
1. Does the midwife take the child's history and physical examination?			
2. Does the midwife conduct auditory and visual screening on the child?			
3. Does the midwife look for signs of abuse/maltreatment?			

B. Midwife Gives Advice	YES	NO	N/A
1. Does the midwife give advice on the following:			
a. Fertility awareness and responsible sexuality?			
b. Healthy diet and physical activity?			
c. Dangers of drugs, alcohol and tobacco?			
d. Awareness on physical, emotional and sexual abuse?			

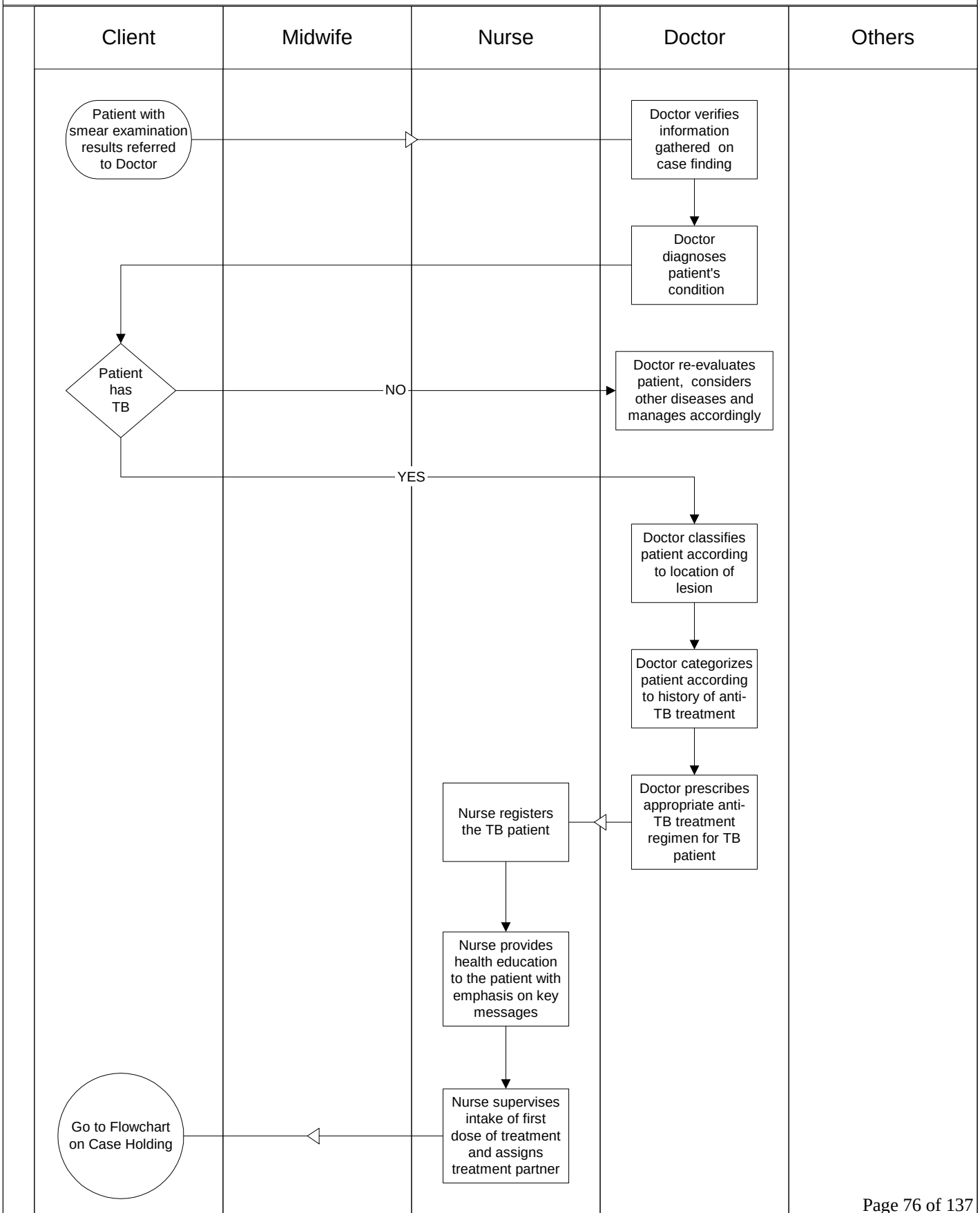
C. Midwife Refers Child for Dental Check-Up	YES	NO	N/A
1. Does the midwife refer the child for dental check-up?			
2. Does the midwife give advice on proper toothbrushing?			

D. Midwife Advises Mother/Caregiver When to Return	YES	NO	N/A
1. Does the midwife advise the mother/caregiver when to bring the child back to the RHU/HC?			

National Tuberculosis Program
RHU Supervisory Flowchart: Case Finding



National Tuberculosis Program
RHU Supervisory Flowchart: Diagnosis and Initiation of Treatment



National Tuberculosis Program
Supervisory Checklist

I. Case Finding

A. Midwife Identifies and Registers Patient as TB Symptomatic	YES	NO	N/A
1. Does the midwife identify TB symptomatics as persons having cough for two or more weeks duration with or without accompanying signs and symptoms?			
2. Does the midwife employ passive case finding (the staff wait for TB symptomatics to consult at the health facility)?			
3. Does the midwife register the TB symptomatic in the TB Symptomatics Masterlist and advise him/her top undergo sputum examination as soon as possible?			

B. Midwife Explains the Purpose of the Sputum Examination and Demonstrates How to Produce Good Sputum	YES	NO	N/A
1. Does the midwife explain the purpose of the sputum examination to the TB symptomatic before collecting the specimen?			
2. Does the midwife demonstrate how to produce good sputum by asking the patient to breathe deeply and at the height of inspiration, ask the patient to cough strongly and spit the sputum in the container?			

C. Midwife Collects 3 Sputum Specimens from the Patient Within 2 Days	YES	NO	N/A
1. Does the midwife collect three sputum specimens within two days according to the following procedures?			
a. First specimen or spot specimen: It is collected at the time of consultation or as soon as the Tb symptomatic is identified.			
b. Second specimen or early morning specimen: It is the very first sputum produced in the morning and collected by the patient according to the instructions given by the midwife.			
c. Third specimen or spot specimen: It is collected at the time the TB symptomatics comes back to the health facility to submit the second specimen.			

D. Midwife Follows-Up Patient and Convinces Him to Submit 3 Sputum Specimens	YES	NO	N/A
1. Does the midwife follow-up TB symptomatics who fail to submit 3 sputum specimens and convinces him/her to do so?			

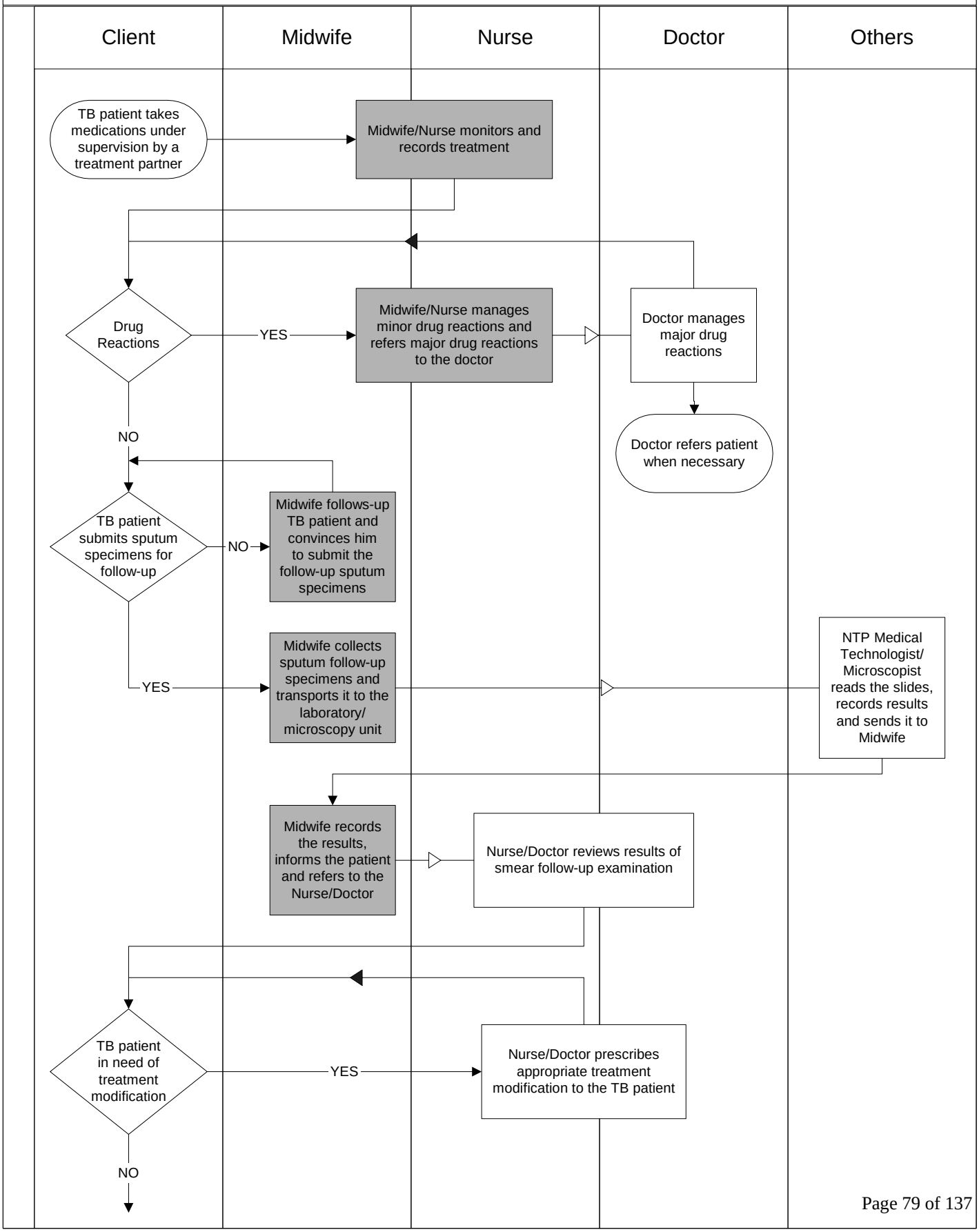
E. Midwife Properly Labels, Seals and Secures the Sputum Specimen Collected and Transports It to the Microscopy Unit or Laboratory	YES	NO	N/A
1. Does the midwife label the body of the sputum cup with the patient's complete name and the name of the referring unit?			
2. Does the midwife seal each sputum container, pack it securely and transport the same to a microscopy unit or laboratory as soon as possible or not later than four days from collection?			
3. Does the midwife send the specimen together with the properly filled up laboratory request form to the microscopy center?			

F. Midwife Records the Results	YES	NO	N/A
1. Does the midwife record the results of the sputum examination in the TB Symptomatics Masterlist?			

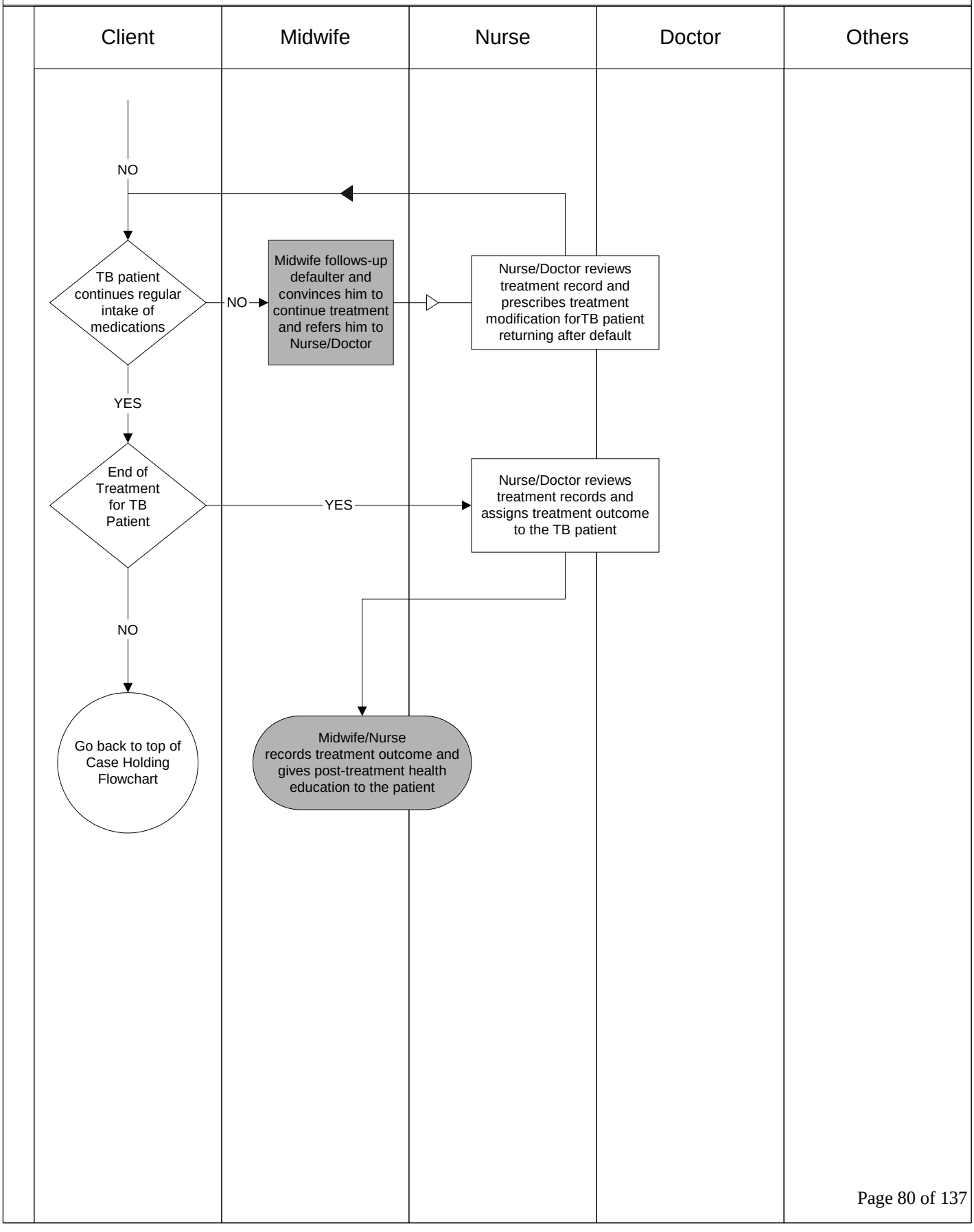
G. Midwife Informs and Explains the Result to the Patient	YES	NO	N/A
1. Does the midwife inform and explain to the TB symptomatic the result of the sputum examination? a. Smear positive: Occurs when at least two sputum smear results are positive. b. Doubtful: Shows only one positive out of three sputum specimens examined. c. Smear negative: Shows that all three sputum smear results are negative.			
2. Does the midwife immediately collect another 3 sputum specimens for confirmation when the result is doubtful?			

H. Midwife Refers the Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer the patient to the doctor together with the results of the sputum examination?			

National Tuberculosis Program
RHU Supervisory Flowchart: Case Holding



National Tuberculosis Program
RHU Supervisory Flowchart: Case Holding



II. Case Holding

A. Midwife Monitors and Records Treatment	YES	NO	N/A
1. Does the midwife ensure that the patient's drugs are administered daily?			
a. The patient and his/her treatment partner meet at their agreed treatment unit everyday.			
b. The treatment partner makes sure that the patient swallows his/her drugs daily.			
c. After intake of the drugs, the treatment partner checks and signs the treatment partner's NTP ID Card as well as the patient's NTP ID Card.			
d. On Saturdays, Sundays and holidays, when the health center or clinic is closed, treatment could be done at home but should be supervised by a family member.			
2. Does the midwife conduct regular (preferably weekly) consultation meetings with the treatment partner together with the patient for treatment evaluation at the RHU/HC?			
3. Does the midwife record drug intake and other pertinent information in the NTP Treatment Card?			

B. Midwife Manages Minor Drug Reactions and Refers Major Drug Reactions to the Doctor	YES	NO	N/A
1. Does the midwife manage minor drug reactions accordingly?			
a. Gastro-intestinal intolerance (Rifampicin): Give medications at bedtime.			
b. Mild skin reactions (Any kind of drugs): Give anti-histamines.			
c. Orange/red colored urine (Rifampicin): Reassure the patient.			
d. Pain at the injection site (Streptomycin): Apply warm compress; rotate sites of injection.			
e. Burning sensation in the feet due to peripheral neuropathy (Isoniazid): Give Pyridoxine (Vitamin B6) at 100-200 mg daily for treatment and 10 mg daily for prevention.			
f. Arthralgia due to hyperuricemia (Pyrazinamide): Give aspirin or NSAID; if symptoms persist, consider gout and give allopurinol.			
g. Flu-like symptoms such as fever, muscle pains, inflammation of the respiratory tract (Rifampicin): Give anti-pyretics.			
2. Does the midwife encourage patients suffering from minor side effects to continue taking medicines?			
3. Does the midwife discontinue medicines and refer patients with major side effects to the medical officer immediately?			
a. Severe skin rash due to hypersensitivity.			
b. Jaundice due to hepatitis.			
c. Impairment of visual acuity and color vision due to optic neuritis.			
d. Hearing impairment, ringing of the ear and dizziness due to damage to the eighth cranial nerve.			
e. Oliguria or albuminuria due to renal disorder.			
f. Psychosis and convulsion.			
g. Thrombocytopenia, anemia, shock.			

C. Midwife Collects Sputum Follow-Up Specimens and Transports It to the Laboratory/Microscopy Unit	YES	NO	N/A
1. Does the midwife monitor the response to treatment through follow-up sputum examination done on the specified dates?			
a. Category I i. Towards end of 2nd and 4th month and beginning of the 6th month of treatment. ii. If the follow-up smear result is positive at the end of the 2nd month, extend HRZE for one more month and follow-up sputum examinations towards the end of the 3rd, 5th and 6th month of treatment. iii. Check the follow-up sputum smear examination at the end of treatment for the patient who has smear positive in the last follow-up smear examination and shows smear negative in the repeated smear examination.			
b. Category II i. Towards the end of the 3rd and 5th month and beginning of the 8th month of treatment. ii. If the follow-up smear result is positive at the end of the 3rd month, extend HRZE for one more month and follow-up sputum examinations towards the end of the 4th, 6th and 8th month of treatment. iii. Check the follow-up sputum smear examination at the end of treatment for the patient who has smear positive in the last follow-up smear examination and shows smear negative in the repeated smear examination.			
c. Category III i. Towards the end of the 2nd month of treatment.			
2. Does the midwife require only one sputum specimen (preferably collected in the early morning) for follow-up sputum smear examination?			

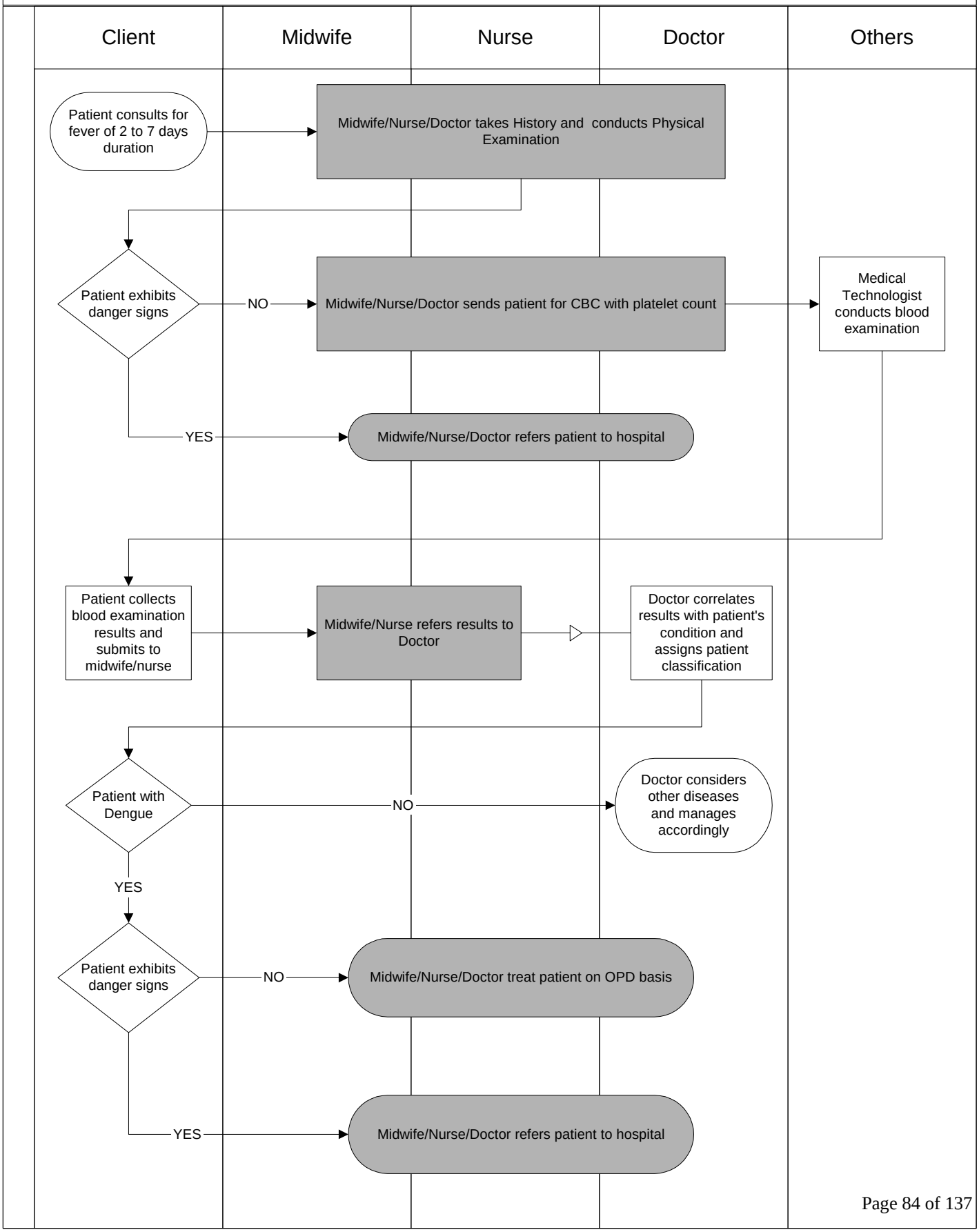
D. Midwife Follows-Up TB Patient and Convinces Him to Submit the Follow-Up Sputum Specimen	YES	NO	N/A
1. Does the midwife follow-up TB patient who fail to submit follow-up sputum specimen on specified dates?			

E. Midwife Records the Results, Informs the Patient and Refers to the Nurse/Doctor	YES	NO	N/A
1. Does the midwife record the results of follow-up sputum examination in the NTP Treatment Card?			
2. Does the midwife inform the patient of the result of the follow-up sputum examination?			
3. Does the midwife refer the result of the follow-up sputum examination to the Nurse/Doctor?			

F. Midwife Follow-Up Defaulter and Convinces Him to Continue Treatment and Refers Him to Nurse/Doctor	YES	NO	N/A
1. Does the midwife and treatment partner immediately exert effort to retrieve a patient upon failure to report on the day the patient is expected?			
2. Does the midwife regularly motivate the TB patient to continue treatment by emphasizing key messages, such as:			
a. TB could be cured but requires regular drug intake for the prescribed duration.			
b. The patient should report any adverse reaction to the drugs.			
c. The patient should undergo follow-up sputum examination on specified dates.			
3. Does the midwife refer defaulters returning for treatment to the Nurse/Doctor?			

G. Midwife Records Treatment Outcome and Gives Post-Treatment Health Education to the Patient	YES	NO	N/A
1. Does the midwife record the treatment outcome in the NTP Treatment Card and the NTP Register?			
a. Cure: A sputum smear positive patient who has been completed treatment and is sputum smear negative in the last month of treatment and on at least one occasion. *(Note: We have changed the definition of "cure" as above, however, we have not changed the policy to collect follow-up sputum specimen with three occasions for smear positive case – at the end of the intensive phase, in the middle of the maintenance phase and at the end of the maintenance phase.)*			
b. Treatment Completed: A patient who has completed treatment but does not meet the criteria to be classified as cure or failure. This group includes: • A sputum smear-positive patient initially who has completed treatment without follow-up sputum examinations during the treatment, or with only one negative sputum examination during the treatment, or without sputum examination in the last month of treatment. • A sputum smear-negative patient who has completed treatment.			
c. Died: A patient who dies for any reason during the course of treatment.			
d. Treatment Failure: • A patient who is sputum smear-positive at five months or later during treatment. • A sputum smear negative initially before starting treatment and becomes smear positive during the treatment. *(Note: This case will be re-registered as "Other" with a new TB case number)*			
e. Defaulter: A patient whose treatment was interrupted for two consecutive months or more.			
f. Transfer out: A patient who has been transferred to another facility with proper referral/transfer slip for continuation of treatment.			
2. Does the midwife provide post-treatment health education to the patient?			

National Dengue Prevention and Control Program
RHU Supervisory Flowchart



National Dengue Prevention and Control Program
Supervisory Checklist

A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife elicit pertinent information during history taking such as:			
a. History of acute febrile illness for 2 to 7 days duration.			
b. Presence of associated signs and symptoms such as headache, retro-orbital pain, myalgia, arthralgia, and rashes.			
c. Presence of bleeding and/or hemorrhagic manifestations.			
2. Does the midwife conduct regional examination and look for hemorrhagic manifestations such as:			
a. Petechiae			
b. Ecchymosis or purpura			
c. Bleeding from mucosa, GIT, injection or other sites			
d. Hematemesis			
e. Melena			
f. Rapid and weak pulse			
g. Narrow pulse pressure or hypotension for age			
h. Cold, clammy skin and restlessness			
3. Does the midwife do the torniquet test according to the recommended procedure?			
a. Place the cuff (corresponding cuff appropriate for age) of a sphygmomanometer around the arm in the usual manner.			
b. Inflate to a pressure halfway between the systolic and diastolic levels.			
c. Maintain compression for five minutes and wait two minutes or more for observation.			
d. Describe an area 1 square inch on the volar surface of the forearm 1 ½ inch distal from the ante-cubital fossa.			
e. Count the petechiae within this prescribed area.			
f. A positive torniquet test is $\geq$ 20 petechiae.			
4. Does the midwife exempt patients with petechiae or Herman's rash from the torniquet test?			

B. Midwife Sends Patient for CBC with Platelet Count	YES	NO	N/A
1. Does the midwife refer patients consulting for fever of 2 to 7 days duration for CBC and Platelet Count examination?			

C. Midwife Refers Patient (exhibiting danger signs) to the Hospital	YES	NO	N/A
1. Does the midwife correctly identify the presence of one or more danger signs (especially during defervescence) in a patient with fever of 2 to 7 days duration?			
a. Spontaneous bleeding			
b. Persistent abdominal pain			
c. Persistent vomiting			
d. Listlessness			
e. Change in mental status			
f. Restlessness			

	YES	NO	N/A
g. Weak, rapid pulse			
h. Cold, clammy skin			
i. Circumoral cyanosis			
j. Difficulty of breathing			
k. Seizures			

D. Midwife Refers Results to the Doctor	YES	NO	N/A
1. Does the midwife refer immediately the results of the blood examination to the doctor?			

E. Midwife Treats Patient on OPD Basis	YES	NO	N/A
1. Does the midwife recognize what are the manifestations of a dengue patient with no danger signs?			
q. History of fever of 2 to 7 days duration.			
r. Skin flushing or rashes and/or positive torniquet test			
2. Does the midwife treat dengue patients exhibiting no danger signs on an out-patient basis?			

Table 1. Out-Patient Dengue Case Management

What to Give	*What to Monitor*	*Where Patient Must Go*
• *Give ORESOL to replace fluids as in moderate dehydration at 75 ml/KBW in 4-6 hours or up to 2-3 liters in adults.* • *Give PARACETAMOL for fever. Do not use ASPIRIN.* *ORESOL PLAN B (replace fluids in 4-6 hours)* *Age — Weight — Amount* *Up to 4 mos. — <6 kgs. — 200-400 ml* *4-12 mos. — 6-10 kgs. — 400-700 ml* *>1-2 years — 10-12 kgs — 700-900 ml* *2-5 years — 12-19 kgs — 900-1400 ml*	• *Assess patient daily for danger signs.* • *Get platelet count and hematocrit once a day until patient becomes afebrile for 72 hours; may include bleeding time.* • *If platelet count, hematocrit or bleeding time are not available, watch out for danger signs.*	• *Send patient home.* • *Ask patient to come back until 72 hours afebrile or immediately if there is any danger sign.*

F. Midwife Refers Patient to the Hospital (dengue patient exhibiting danger signs)	YES	NO	N/A
1. Does the midwife correctly identify the presence of one or more danger signs (especially during defervescence) in patients with dengue?			
a. Spontaneous bleeding			
b. Persistent abdominal pain			
c. Persistent vomiting			
d. Listlessness			
e. Change in mental status			
f. Restlessness			
g. Weak, rapid pulse			
h. Cold, clammy skin			
i. Circumoral cyanosis			

	YES	NO	N/A
j. Difficulty of breathing			
k. Seizures			
l. Hypotension or narrowing of pulse pressure (<20 mm Hg)			
m. Platelet count <100,000 cells/cu. mm or 1-2 platelets/oil immersion field			
n. Hemoconcentration (rise in >20% above average or 20% drop following treatment with fluids as compared to baseline)			
o. Prolonged bleeding time (>5 minutes by Ivy method)			
2. Does the midwife immediately refer dengue patients exhibiting danger signs to the hospital?			

National Rabies Prevention and Control Program
RHU Supervisory Form

National Rabies Prevention and Control Program
Supervisory Checklist

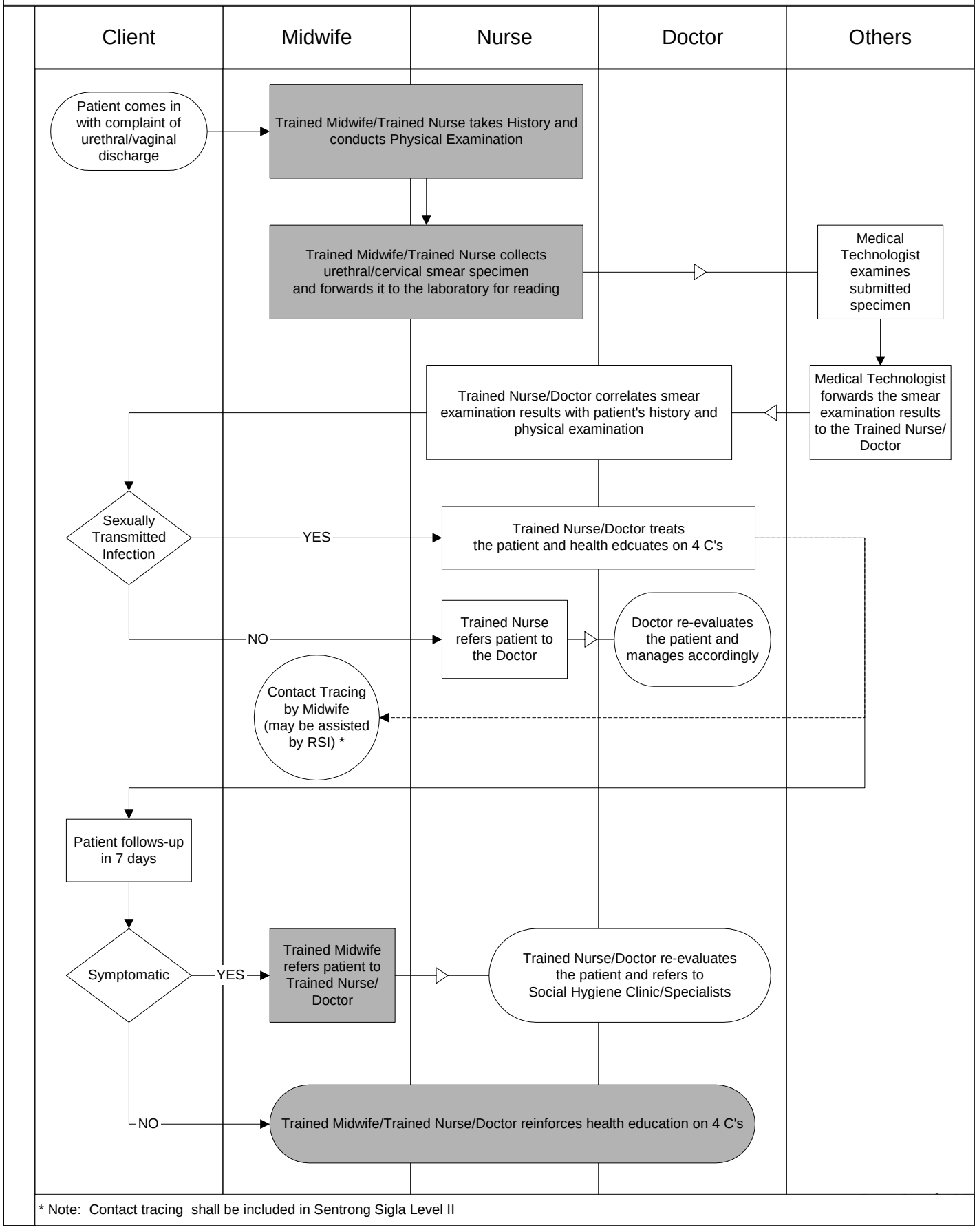
A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife ask for pertinent information on all patients who consult for animal/human bite or contact with "probable" rabid animal/human or suspect?			
a. Type of biting animal/contact.			
b. Immunization history of biting animal/human or contact.			
c. Circumstances surrounding the "biting incident"			
i. When and where (e.g. house, street, etc.) patient was bitten.			
ii. Bite/Contact site.			
iii. Reason why patient was bitten/came into contact.			
iv. Description of biting/contact animal/human.			
v. Owner of biting/contact animal to include status (pet or stray).			
2. Does the midwife perform initial physical examination of the bite site?			
a. Site of bite.			
b. Description of the bite (e.g. lick, abrasion, laceration, etc.)			

B. Midwife Provides Initial Management	YES	NO	N/A
1. Does the midwife advise the patient to wash the bite site with soap and continuously flowing water for at least 10 minutes?			
2. Does the midwife apply antiseptics on the bite site and give oral analgesics for pain?			

C. Midwife Conducts Health Education and Counselling	YES	NO	N/A
1. Does the midwife instruct the patient to observe the biting animal and act accordingly?			
a. Observe for behavioral changes in the biting animal, where appropriate, for at least 14 days and consult immediately with RHU staff for further evaluation. ▪ Behavioral changes to be observed ▪ Biting indiscriminately ▪ Excessive salivation ▪ Hydrophobia ▪ Death ▪ Etc.			
b. Does the staff consider the biting/contact animal as rabid if it is astray?			
c. If the biting animal dies, patient should coordinate with RHU staff and local veterinary office with regard disposal of carcass and laboratory examination for rabies virus.			
2. Does the midwife advise the patient and his companions on responsible pet ownership?			
a. Leashing of pet animals.			
b. Proper animal feeding, grooming and hygiene.			
c. Animal vaccination against rabies.			

D. Midwife Refers Patient for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer the patient to the doctor/nurse for further evaluation and management?			

Sexually Transmitted Infections
RHU Supervisory Flowchart for Facilities with Laboratory and with Capability



* Note: Contact tracing shall be included in Sentrong Sigla Level II

Program: Sexually Transmitted Infections
Supervisory Checklist for Facilities With Laboratory and With Capability

A. Trained Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife practice the essentials of a good approach when dealing with the patient?			
a. Welcome your patient			
b. Encourage your patient to talk			
c. Look at your patient			
d. Listen to your patient			
2. Does the midwife ask for the following questions during history taking:			
a. General Details			
i. What is your name?			
ii. What is your age?			
iii. How many children do you have?			
iv. Where do you live?			
v. How long have you been there?			
vi. Do you always stay there or have you come from elsewhere?			
b. STD History			
i. Have you ever had STD before?			
ii. What did you have?			
iii. When was it?			
c. Treatment History			
i. Are you taking medicines now?			
ii. What kind of medicines?			
iii. Is it helping you?			
iv. Are you allergic to any kind of medicines?			
v. Have you ever been told not to take certain types of medicines?			
d. Symptoms/Present Illness for All Patients			
i. What is troubling you?			
ii. When did it start?			
iii. How did it start?			
iv. What do you think might have caused the problem?			
v. What do you think the problem might be?			
vi. What have you done for the problem before the visit?			
e. Symptoms/Present Illness for Patient Complaining of a Sore			
i. Is the sore painful?			
ii. Do you have pain in the groin?			
iii. Do you have swelling in the groin?			

	YES	NO	N/A
f. Symptoms/Present Illness for Female Patient			
i. Do you have pain in the lower abdomen?			
ii. Do you have pain when you have sexual intercourse?			
iii. Do you have unusual vaginal discharge?			
iv. When did you have your monthly period?			
v. Was the period unusual in any way?			
vi. Have you missed any period?			
vii. Are you late for a period?			
viii. Do you have bleeding or bleeding between periods?			
ix. Are you using any kind of birth control method?			
g. Sexual History for All Patients			
i. When did you last have sex?			
ii. Does she/he have any symptoms?			
iii. Before this, when did you last have sex?			
iv. Does she/he have any symptoms?			
v. In the last three months, how many different partners have you had sex with?			
vi. In the last three months, have you been with a new partner?			
vii. Do you have a regular partner?			
viii. When did you have sex with him/her?			
ix. Does your regular partner have any symptoms of STD?			
x. Are you married?			
xi. Did you or your partner use a condom the last time you had sex?			
xii. Have you had ever used a condom?			
3. Does the midwife consider the following when conducting physical examination:			
a. Ensure privacy.			
b. Explain what you are going to do and why examination is important.			
c. Even though you have little time to examine the patient, never be rough with him or her.			
d. Examination is best done when the service provider is the same gender; however, in instances when the service provider is male, offer female patients the opportunity to have someone else present if they prefer.			
4. Does the midwife conduct physical examination for male patients in the following manner:			
a. Tell him what you are going to do before you do it.			
b. Ask the patient to take his pants and underwear down.			
c. Look at the penis with the foreskin forward and pulled back.			
d. Ask the patient to show any discharge by milking the penis.			
e. Look at the groin, pubic hair region and perineum.			
f. Palpate the groin (for swelling); the testicles for swelling or tenderness.			
g. Preferably with the patient lying on one side, examine the perineum, anus and perianal area.			

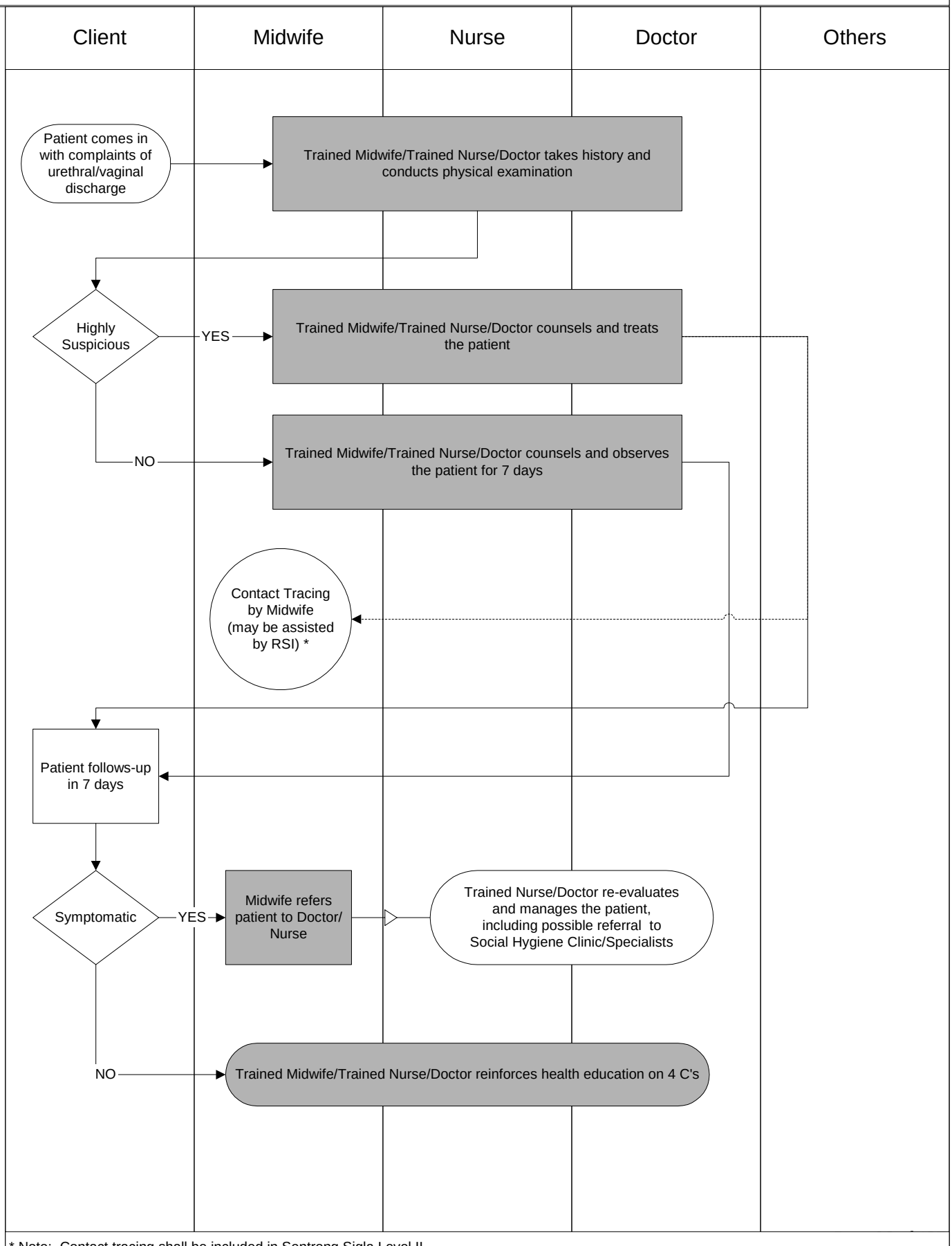
	YES	NO	N/A
h. Note for the following:			
i. Genital and body rashes, ulcers, swollen glands in the groin.			
ii. Scabies lesions, pubic lice and nits.			
iii. Discharge from the urethra.			
iv. Anal or perianal rashes or ulceration.			
5. Does the midwife conduct physical examination for female patients in the following manner:			
a. Tell her what you are going to do before you do it.			
b. Ask the patient to remove her underwear.			
c. Examine the patient on a couch or table on her back with the knees flexed.			
d. Look at the external genitalia, perineum, perianal and anal region.			
e. Palpate the groins for swelling.			
f. With a gloved hand, separate the outer labia. Look at the inner labia, separate them and look at the introitus.			
g. Note for ulcers, redness, rashes.			
6. Does the midwife conduct physical examination using a sterile speculum on a female patient in the following manner:			
a. With the other hand, insert the speculum and open it. Locate the cervix between the blades.			
b. Look at the cervix and its opening (cervical os), the vaginal vault and as you remove the speculum, look at the walls of the vagina.			
c. Note for the following:			
i. Warts			
ii. Sores and ulcers			
iii. Color, quantity and smell of vaginal discharge			
iv. The character of the exudates from the cervix – is it clear, mucoid, mucopus or frank pus? Does it contain blood?			
v. Scabies lesions, pubic lice and nits			
vi. Swollen glands in the groin			
vii. Anal or perianal rashes or ulcerations			

B. Trained Midwife Collects Urethral/Cervical Smear Specimen and Forwards It to the Laboratory for Reading	YES	NO	N/A
1. Does the midwife collect urethral smear specimens from male patients and forward it to the laboratory for reading?			
2. Does the midwife collect cervical smear specimens from female patients and forward it to the laboratory for reading?			

C. Trained Midwife Refers Patient to Trained Nurse/Doctor	YES	NO	N/A
1. Does the midwife refer patient who is still symptomatic despite treatment to the trained nurse/doctor?			

D. Trained Midwife Reinforces Counseling on 4 C's	YES	NO	N/A
1. Does the midwife reinforce the essential educational messages of STD (4 C's)?			
a. Compliance			
i. Completing all the treatment prescribed.			
ii. Following prevention recommendation successfully.			
b. Counseling/Education			
i. About the disease and about the treatment.			
ii. How to avoid catching an STD again.			
iii. About HIV and AIDS.			
c. Contact Tracing			
i. Making sure all sexual partners are encouraged to get treatment.			
d. Condoms			
i. Promoting consistent/correct condom use and providing them.			
ii. Helping negotiate condom use with partners.			

Sexually Transmitted Infections
RHU Supervisory Flowchart for Facilities with No Laboratory or with Laboratory but with no Capability



* Note: Contact tracing shall be included in Sentrong Sigla Level II

Program: Sexually Transmitted Infections
Supervisory Checklist for Facilities With No Laboratory or With Laboratory but With No Capability

A. Trained Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife practice the essentials of a good approach when dealing with the patient?			
a. Welcome your patient			
b. Encourage your patient to talk			
c. Look at your patient			
d. Listen to your patient			
2. Does the midwife ask for the following questions during history taking:			
a. General Details			
i. What is your name?			
ii. What is your age?			
iii. How many children do you have?			
iv. Where do you live?			
v. How long have you been there?			
vi. Do you always stay there or have you come from elsewhere?			
b. STD History			
i. Have you ever had STD before?			
ii. What did you have?			
iii. When was it?			
c. Treatment History			
i. Are you taking medicines now?			
ii. What kind of medicines?			
iii. Is it helping you?			
iv. Are you allergic to any kind of medicines?			
v. Have you ever been told not to take certain types of medicines?			
d. Symptoms/Present Illness for All Patients			
i. What is troubling you?			
ii. When did it start?			
iii. How did it start?			
iv. What do you think might have caused the problem?			
v. What do you think the problem might be?			
vi. What have you done for the problem before the visit?			
e. Symptoms/Present Illness for Patient Complaining of a Sore			
i. Is the sore painful?			
ii. Do you have pain in the groin?			

iii. Do you have swelling in the groin?			

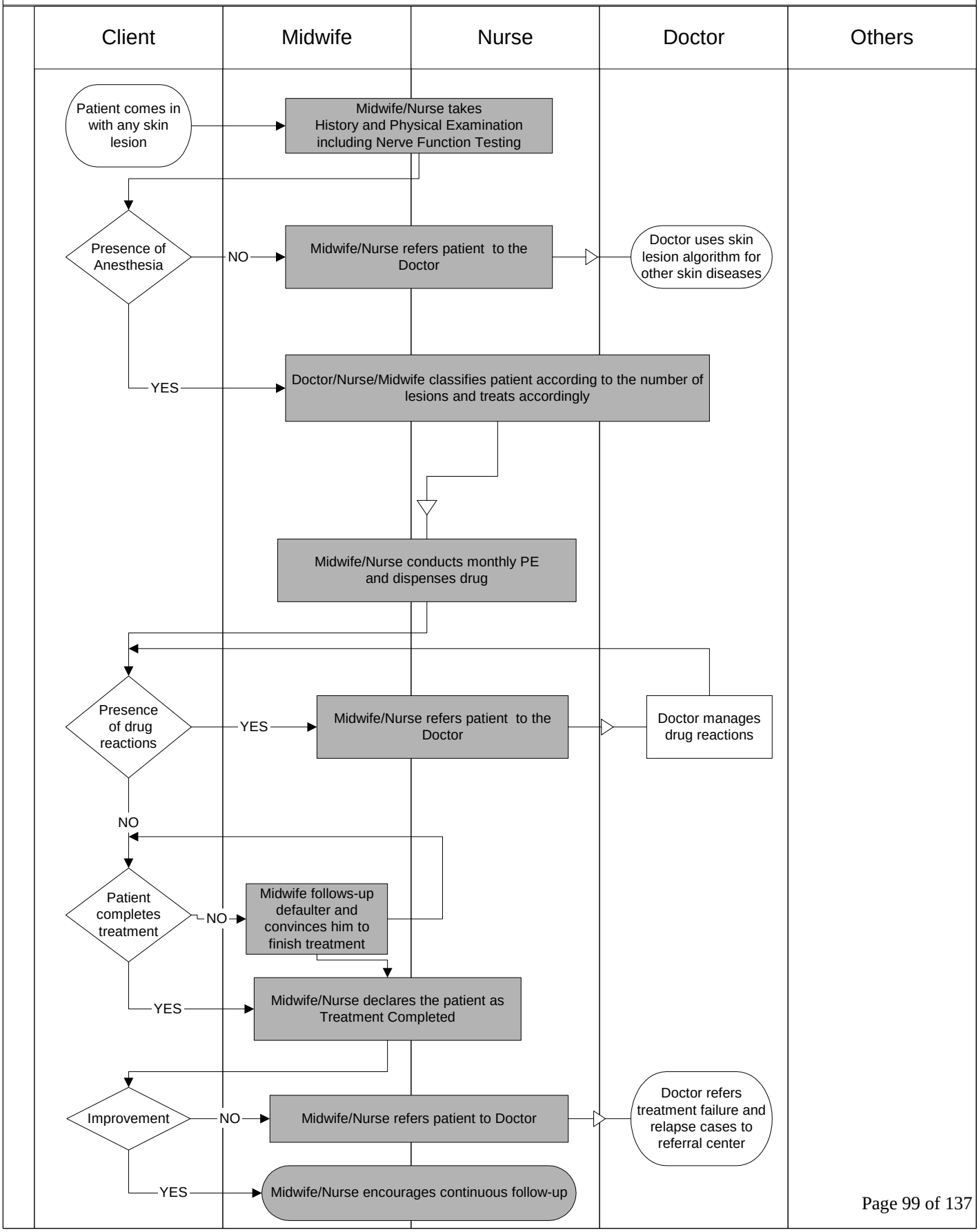
B. Trained Midwife Counsels and Treats the Patient	YES	NO	N/A
1. Does the midwife provide the essential educational messages of STD (4 C's)?			
a. Compliance			
i. Completing all the treatment prescribed.			
ii. Following prevention recommendation successfully.			
b. Counseling/Education			
i. About the disease and about the treatment.			
ii. How to avoid catching an STD again.			
iii. About HIV and AIDS.			
c. Contact Tracing			
i. Making sure all sexual partners are encouraged to get treatment.			
d. Condoms			
i. Promoting consistent/correct condom use and providing them.			
ii. Helping negotiate condom use with partners.			
2. Does the midwife provide syndromic case management for urethral discharge?			
a. Cefixime 400 mg as a single oral dose plus			
b. Doxycycline 100 mg orally twice daily for 7 days			
3. Does the midwife provide syndromic case management for vaginal discharge?			
a. Cefixime 400 mg as a single oral dose plus			
b. Doxycycline 100 mg orally twice daily for 7 days plus			
c. Metronidazole 2 grams in a single dose plus			
d. Clotrimazole 200 mg tablet per vagina for three consecutive nights			
4. Does the midwife provide syndromic case management for vaginitis?			
a. Metronidazole 2 grams in a single dose plus			
b. Clotrimazole 200 mg tablet per vagina for three consecutive nights			

C. Trained Midwife Counsels and Observes the Patient for 7 Days	YES	NO	N/A
1. Does the midwife counsel and observe non-highly suspicious STI patients for 7 days?			

D. Trained Midwife Refers Patient to the Doctor/Nurse	YES	NO	N/A
1. Does the midwife refer patients still symptomatic after 7 days to the Trained Nurse/Doctor?			

E. Trained Midwife Reinforces Health Education on 4 C's	YES	NO	N/A
1. Does the midwife reinforce health education messages on the 4 C's?			

National Leprosy Prevention and Control Program
RHU Supervisory Checklist



National Leprosy Prevention and Control Program
Supervisory Checklist

A. Midwife Takes History and Physical Examination including Nerve Function Testing	YES	NO	N/A
1. Does the midwife elicit pertinent information during history taking?			
a. Presence of any skin lesions.			
b. Presence of anesthetic skin lesions.			
c. Previous contact with a leprosy patient.			
2. Does the midwife perform a thorough physical examination?			
a. In looking for skin lesions, were all the patient's clothing stripped off during the physical examination?			
b. Was nerve function testing done accurately?			
o Was a pointed-blunt object (e.g. pen ballpoint) pressured over the skin lesions?			
o Was the patient blindfolded during the nerve function testing?			
o Was the patient made to respond (if he felt pressure) every after each testing?			
o Was nerve function testing done on more than 5 skin lesions?			

B. Midwife Refers Patient to the Doctor (No Anesthesia)	YES	NO	N/A
1. Does the midwife refer to the doctor patients whose skin lesions tests negative for anesthesia?			

C. Midwife Classifies Patient According to the Number of Lesions and Treats Accordingly	YES	NO	N/A
1. Does the midwife correctly classify patients according to the number of anesthetic lesions?			
a. Single Lesion Paucibacillary (SLPB): solitary anesthetic skin lesion			
b. Paucibacillary (PB): 2 to 5 anesthetic skin lesions			
c. Multibacillary (MB): more than 5 anesthetic skin lesions			

	YES	NO	N/A
2. Does the midwife provide the appropriate treatment regimen based on the classification?			

Table 1. Leprosy Treatment Regimen According to Classification

Classification	Drug	Adult	Pediatric (≤ 15 years old)	Number of MDT Blister Packs
Single Lesion Paucibacillary (SLPB)	Rifampicin Ofloxacin Minocycline	600 mg 400 mg 100 mg	300 mg 200 mg 50 mg	ONE as single dose.
Paucibacillary (PB)	<u>Day 1</u> Rifampicin Dapsone <u>Days 2 to 28</u> Dapsone	<u>Day 1</u> 600 mg 100 mg <u>Days 2 to 28</u> 100 mg	<u>Day 1</u> 450mg 50mg <u>Days 2 to 28</u> 50mg	SIX to be taken monthly within a maximum period of NINE months.
Multibacillary (MB)	<u>Day 1</u> Rifampicin Dapsone Clofazimine <u>Days 2 to 28</u> Dapsone Clofazimine	<u>Day 1</u> 600 mg 100 mg 300 mg <u>Days 2 to 28</u> 100 mg 50mg	<u>Day 1</u> 450 mg 50 mg 150 mg <u>Days 2 to 28</u> 50 mg 50 mg every other day	TWELVE to be taken within a maximum period of EIGHTEEN months.

D. Midwife Conducts Monthly Physical Examination and Dispenses Drugs	YES	NO	N/A
1. Does the midwife perform monthly physical examination on patients undergoing treatment?			
2. Does the midwife provide monthly supply of MDT drugs for PB and MB patients?			

E. Midwife Refers Patient to the Doctor (Presence of Drug Reactions)	YES	NO	N/A
1. Does the midwife refer patients with drug reactions to the doctor?			

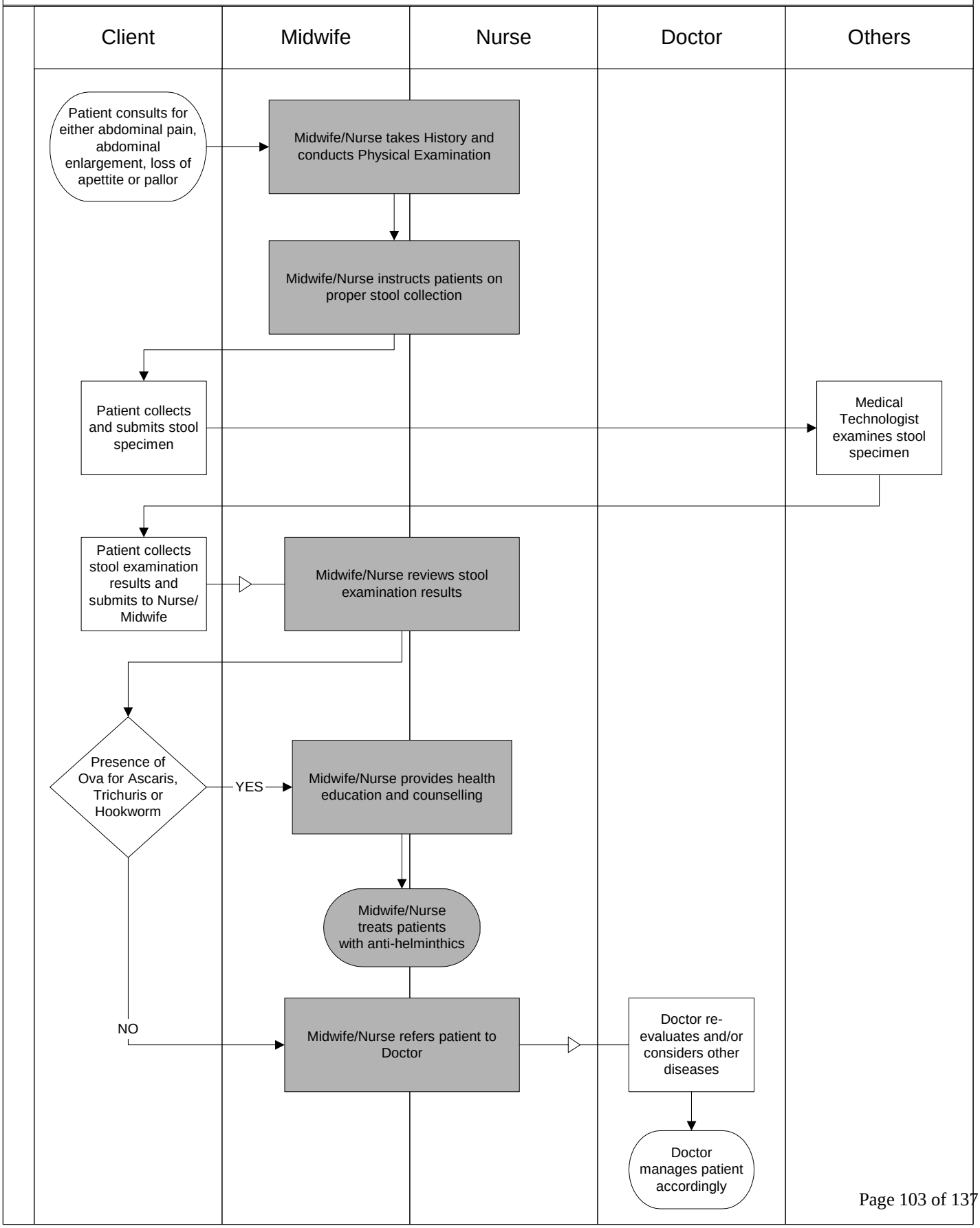
F. Midwife Follows-Up Defaulter and Convinces Him to Finish Treatment	YES	NO	N/A
1. Does the midwife follow-up defaulters and convince them to finish treatment?			
2. Does the midwife convey the following health messages when convincing a defaulter to resume treatment:			
a. Daily intake of MDT is the best method of treatment.			
b. Medications should be taken within the prescribed duration.			
c. Adequate treatment will prevent the transmission of leprosy.			
d. Schedule regular monthly check-up at the health facility.			
e. Consult immediately for painful and enlarged lesions or when new lesions appear.			

G. Midwife Declares the Patient as Treatment Completed	YES	NO	N/A
1. Does the midwife declare all patients who finish treatment as having Treatment Completed?			

H. Midwife Refers Patient to the Doctor (when there is no improvement)	YES	NO	N/A
1. Does the midwife refer patients showing no improvement despite treatment to the doctor?			

I. Midwife Encourages Continuous Follow-Up	YES	NO	N/A
1. Does the midwife encourage patients who completed treatment to follow-up monthly at the health facility for 5 consecutive years?			
2. Does the midwife follow-up those who completed treatment and fail to come back for follow-up?			

Program: Soil Transmitted Helminthiasis
RHU Supervisory Flowchart



Soil Transmitted Helminthiasis
Supervisory Checklist

A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife ask for pertinent information on soil transmitted helminthiasis?			
a. Abdominal pain.			
b. Abdominal enlargement.			
c. Loss of appetite.			
d. Pallor.			
2. Does the midwife conduct physical examination and look for:			
a. Abdominal enlargement.			
b. Pallor.			

B. Midwife Instructs Patient on Proper Stool Examination	YES	NO	N/A
1. Does the midwife instruct the patient on proper stool collection?			
a. Use clean plastic cup, clean bottle or empty tin to directly collect specimen. If container is small mouthed, collect specimen using paper then using an applicator stick, transfer from paper to container.			
b. Amount of specimen collected should be at least the size of a quail's egg.			
c. Cover the lid of the container.			
d. Label specimen container with the name and age of client and the date of collection.			

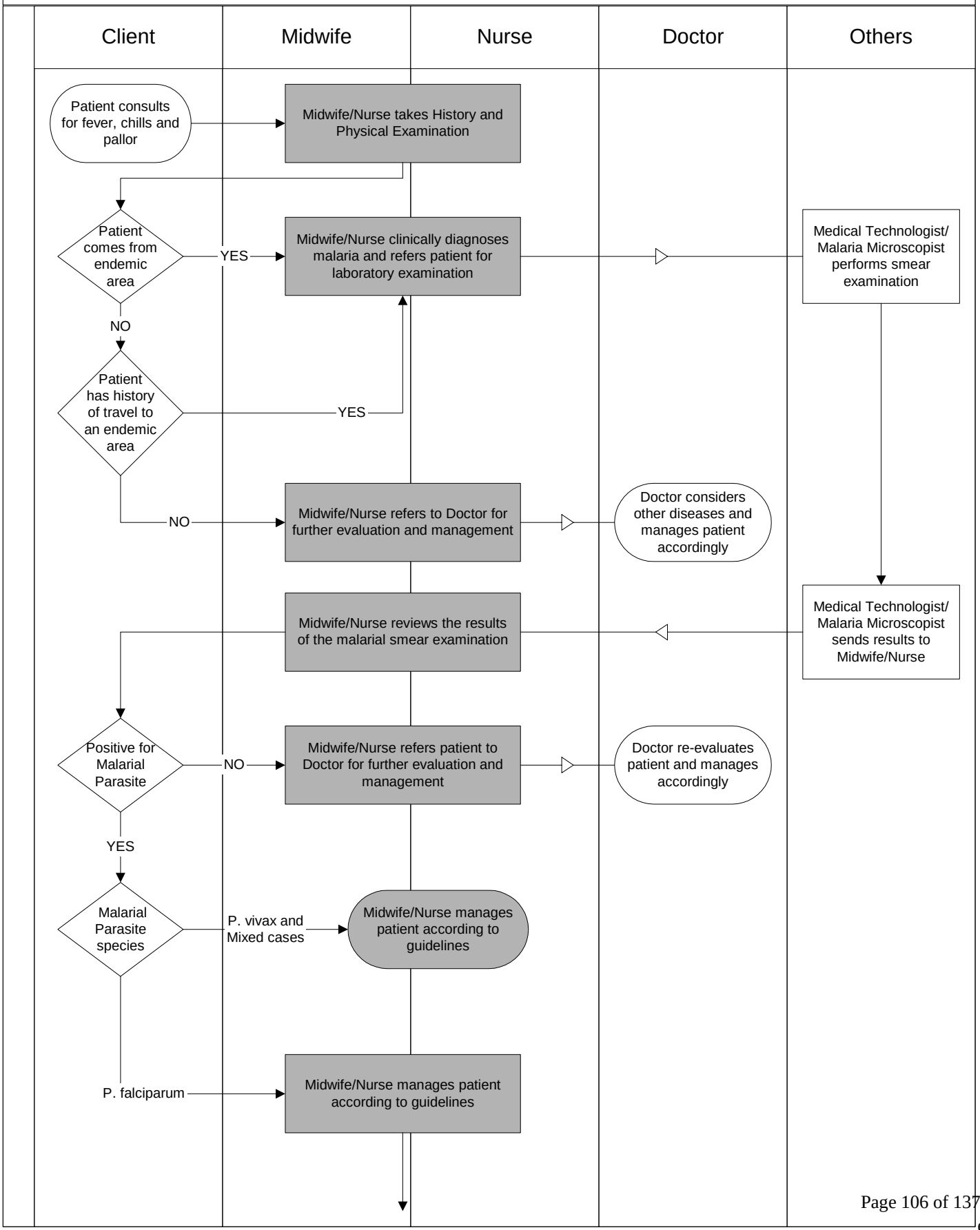
C. Midwife Reviews Stool Examination Results	YES	NO	N/A
1. Does the midwife review if the stool examination results reveal the presence of ascaris, trichuris and/or hookworm ova?			

D. Midwife Provides Health Education and Counselling	YES	NO	N/A
1. Does the midwife give health education and counseling on how to prevent and control intestinal parasitism?			
a. Wash hands before eating and after using the toilet			
b. Wear shoes/slippers always			
c. Use toilet facilities properly			
d. Prepare food in a sanitary manner			
e. Clip finger nails regularly			

E. Midwife Treats Patients with Anti-Helminthics	YES	NO	N/A
1. Does the midwife give Albendazole 400mg or Mebendazole 500 mg chewable tablet single dose If positive for trichuris, ascaris and/or hookworm ova?			
2. Does the midwife advise the patient on the possible transient side effects like rashes, nausea, vomiting and dizziness?			

F. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife consider other diseases and refer to doctor for further evaluation and management If negative for trichuris, ascaris and/or hookworm ova?			

Malaria Prevention and Control Program
RHU Supervisory Flow Chart for Facilities WITH Laboratory



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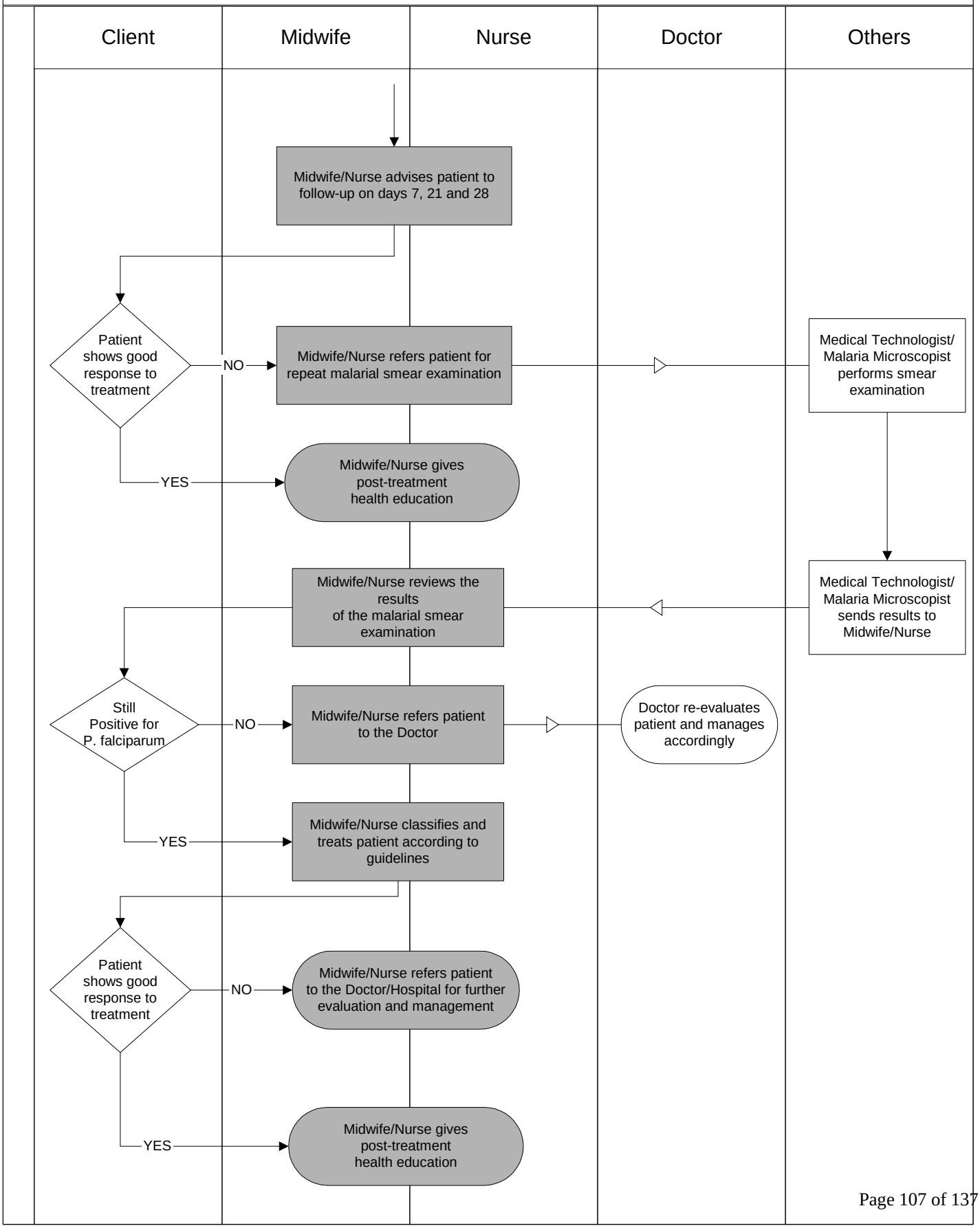
Malaria Prevention and Control Program
RHU Supervisory Checklist for Facilities WITH Laboratory



National Malaria Prevention and Control Program
Supervisory Checklist for Facilities WITH Laboratory

A. Midwife Takes History and Physical Examination	YES	NO	N/A
1. Does the midwife take the clinical history and conduct physical examination on a patient consulting for fever, chills and pallor?			
2. Does the midwife elicit history of travel to a malaria endemic area?			

B. Midwife Clinically Diagnoses Malaria and Refers Patient for Laboratory Examination	YES	NO	N/A
1. Does the midwife clinically diagnose patients as having malaria when the following signs and symptoms are present?			
a. Fever, chills and sweating.			
b. Resident of a malaria endemic area or history of travel to and overnight stay in a malarious area.			
2. Does the midwife refer the patient for malarial blood smear examination?			

C. Midwife Refers to Doctor for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer patients with no history of exposure to the doctor for further evaluation and management?			

D. Midwife Reviews the Results of the Malarial Smear Examination	YES	NO	N/A
1. Does the midwife know that the malarial blood smear examination results can be any of the following?			
a. Plasmodium falciparum			
b. Plasmodium vivax			
c. Plasmodium malariae			
d. Mixed infection			
e. No parasite seen			
2. Does the midwife review the results of the malarial blood smear examination?			

E. Midwife Refers Patients to Doctor for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer patients with no parasite seen in the malarial blood smear examination to the doctor for further evaluation and management?			

F. Midwife Manages Patients According to Guidelines (Plasmodium vivax)	YES	NO	N/A
1. Does the midwife manage patients positive for Plasmodium vivax according to DOH protocol?			

Table 1. Treatment Schedule for Confirmed Plasmodium vivax Cases

Age in Years	Number of Chloroquine Tablets (150 mg base/tablet)			Primaquine (15 mg/tablet)
	Day 1	Day 2	Day 3	1 to 14 days Treatment
0 – 4 months	½	½	½	Not indicated
5 – 11 months	½	½	½	Not indicated
1 – 3 years old	1	1	½	½ daily
4 –6 years old	1 ½	1 ½	1	½ daily
7 – 11 years old	2	2	1	¾ daily
12 – 15 years old	3	3	1 ½	1 daily
16 years old and above	4	4	2	1 daily

F. Midwife Manages Patients According to Guidelines (Mixed cases)	YES	NO	N/A
1. Does the midwife manage patients positive for mixed cases according to DOH protocol?			

Table 2. Treatment Schedule for Mixed P. falciparum and P. vivax Infections

Age in Years	Sulfadoxine/Pyrimethamine (500 mg/25 mg/tablet)	Number of Chloroquine Tablets (150 mg base/tablet)			Primaquine (15 mg/tablet)
	Day 1 Single Dose Only	Day 1	Day 2	Day 3	1 to 14 days Treatment
0 – 4 months	¼	½	½	½	Not indicated
5 – 11 months	½	½	½	½	Not indicated
1 – 3 years old	1	1	1	½	½ daily
4 –6 years old	1	1 ½	1 ½	1	½ daily
7 – 11 years old	1 ½	2	2	1	¾ daily
12 – 15 years old	2	3	3	1 ½	1 daily
16 years old and above	3	4	4	2	1 daily

PLASMODIUM FALCIPARUM CASES

G. Midwife Manages Patients According to Guidelines	YES	NO	N/A
1. Does the midwife manage patients positive for Plasmodium falciparum according to DOH protocol?			

Table 3. Treatment Schedule for Mixed P. falciparum and P. vivax Infections

Age in Years	Sulfadoxine/Pyrimethamine (500 mg/25 mg/tablet)	Number of Chloroquine Tablets (150 mg base/tablet)			Primaquine (15 mg/tablet)
	Day 1 Single Dose Only	Day 1	Day 2	Day 3	Day 4 Single Dose Only
0 – 4 months	¼	½	½	½	Not indicated
5 – 11 months	½	½	½	½	Not indicated
1 – 3 years old	1	1	1	½	½
4 –6 years old	1	1 ½	1 ½	1	1
7 – 11 years old	1 ½	2	2	1	2
12 – 15 years old	2	3	3	1 ½	3
16 years old and above	3	4	4	2	3

H. Midwife Advises Patient to Follow-Up on Days 7, 21 and 28	YES	NO	N/A
1. Does the midwife advise patients positive for Plasmodium falciparum and who has undergone treatment to return for follow-up on days 7, 21 and 28?			

I. Midwife Refers Patient for Repeat Malarial Smear Examination	YES	NO	N/A
1. Does the midwife refer patients showing poor response to treatment for repeat malarial blood smear examination?			

J. Midwife Gives Patient Post-Treatment Health Education	YES	NO	N/A
1. Does the midwife give patients showing good response to treatment post-treatment health education?			

K. Midwife Reviews the Results of the Malarial Smear Examination	YES	NO	N/A
1. Does the midwife review the results of repeat malarial smear examination?			

L. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer patients showing poor response to treatment and were found to be negative for Plasmodium falciparum after the repeat malarial blood smear examination to the doctor for further evaluation and management?			

K. Midwife Classifies and Treats Patient According to Guidelines	YES	NO	N/A
1. Does the midwife classify patients according to the grading of response?			
a. Adequate clinical response			
b. Early treatment failure			
c. Late clinic-parasitological failure			
d. Late parasitological failure			
2. Does the midwife treat patients with parasitological treatment failures according to DOH protocols?			

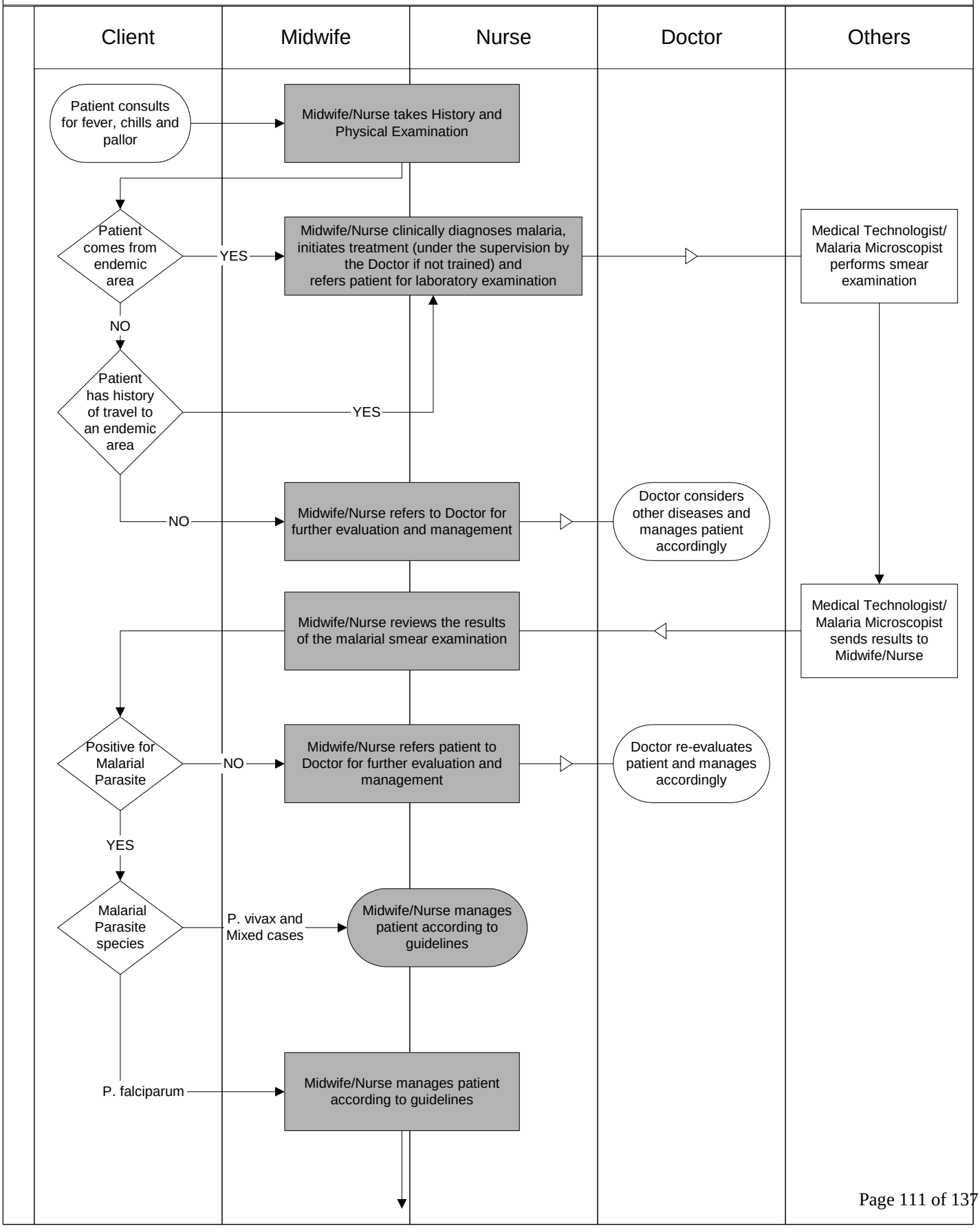
Table 4. Dose and schedule of Artemether-Lumefantrine (20 mg and 120 mg respectively)

Schedule of Treatment	***Adults and Children above 13 years old***	***Pediatric***		
		9 to 13 years	***4 to 8 years***	***1 to 3 years***
Day 1	*4 tablets*	*3 tablets*	*2 tablets*	*1 tablet*
8 hours after	*4 tablets*	*3 tablets*	*2 tablets*	*1 tablet*
Day 2	*4 tablets BID*	*3 tablets BID*	*2 tablets BID*	*1 tablet BID*
Day 3	*4 tablets BID*	*3 tablets BID*	*2 tablets BID*	*1 tablet BID*
Day 4	*Give Primaquine as in Table 3*	*Give Primaquine as in Table 3*	*Give Primaquine as in Table 3*	

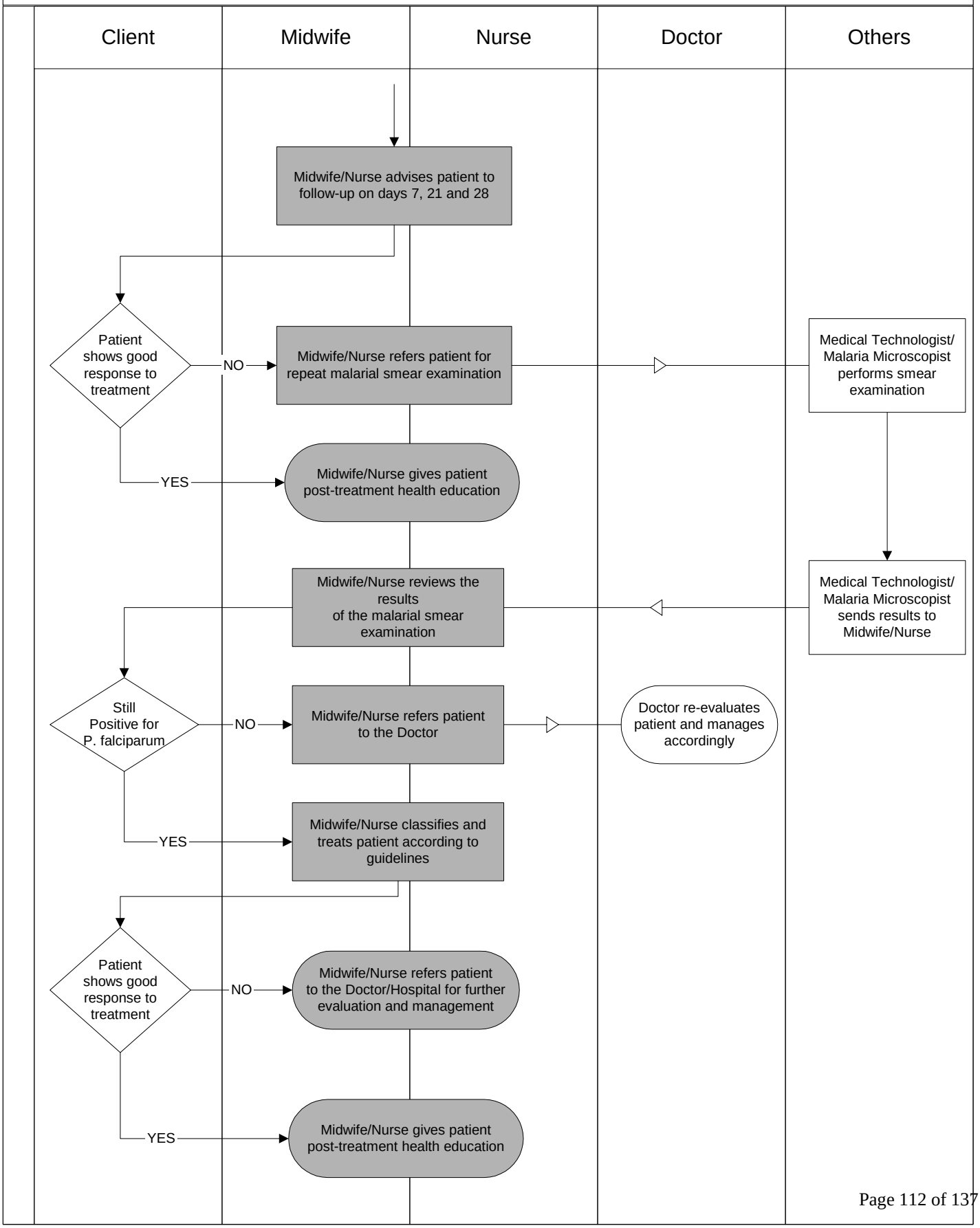
L. Midwife Refers Patient to the Doctor/Hospital for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer patients still showing poor response to treatment after treatment for parasitological treatment failures to the doctor/hospital for further evaluation and management?			

M. Midwife Gives Patient Post-Treatment Health Education	YES	NO	N/A
1. Does the midwife give patients showing good response to re-treatment post-treatment health education?			

Malaria Prevention and Control Program
RHU Supervisory Flow Chart for Facilities WITHOUT Laboratory



Malaria Prevention and Control Program
RHU Supervisory Checklist for Facilities WITHOUT Laboratory



National Malaria Prevention and Control Program
Supervisory Checklist for Facilities WITHOUT Laboratory

A. Midwife Takes History and Physical Examination	YES	NO	N/A
1. Does the midwife take the clinical history and conduct physical examination on a patient consulting for fever, chills and pallor?			
2. Does the midwife elicit history of travel to a malaria endemic area?			

B. Midwife Clinically Diagnoses Malaria, Initiates Treatment (under the supervision by the Doctor if not trained) and Refers Patient for Laboratory Examination	YES	NO	N/A
1. Does the midwife clinically diagnose patients as having malaria when the following signs and symptoms are present?			
a. Fever, chills and sweating.			
b. Resident of a malaria endemic area or history of travel to and overnight stay in a malarious area.			
2. Does the midwife initiate treatment for patients clinically diagnosed as having malaria according to DOH protocols?			

Table 3. Treatment Schedule for Plasmodium falciparum Cases

Age in Years	*Sulfadoxine/Pyrimethamine (500 mg/25 mg/tablet)*	*Number of Chloroquine Tablets (150 mg base/tablet)*			*Primaquine (15 mg/tablet)*
	Day 1 Single Dose Only	*Day 1*	*Day 2*	*Day 3*	*Day 4 Single Dose Only*
0 – 4 months	*¼*	*½*	*½*	*½*	*Not indicated*
5 – 11 months	*½*	*½*	*½*	*½*	*Not indicated*
1 – 3 years old	*1*	*1*	*1*	*½*	*½*
4 –6 years old	*1*	*1 ½*	*1 ½*	*1*	*1*
7 – 11 years old	*1 ½*	*2*	*2*	*1*	*2*
12 – 15 years old	*2*	*3*	*3*	*1 ½*	*3*
16 years old and above	*3*	*4*	*4*	*2*	*3*

3. Does the midwife refer the patient for malarial blood smear examination?			

C. Midwife Refers to Doctor for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer patients with no history of exposure to the doctor for further evaluation and management?			

D. Midwife Reviews the Results of the Malarial Smear Examination	YES	NO	N/A
1. Does the midwife know that the malarial blood smear examination results can be any of the following?			
a. Plasmodium falciparum			
b. Plasmodium vivax			
c. Plasmodium malariae			
d. Mixed infection			
e. No parasite seen			
2. Does the midwife review the results of the malarial blood smear examination?			

E. Midwife Refers Patients to Doctor for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer patients with no parasite seen in the malarial blood smear examination to the doctor for further evaluation and management?			

F. Midwife Manages Patients According to Guidelines (Plasmodium vivax and mixed cases)	YES	NO	N/A
1. Does the midwife manage patients positive for Plasmodium vivax and mixed cases according to DOH protocol?			

PLASMODIUM FALCIPARUM CASES

G. Midwife Manages Patients According to Guidelines	YES	NO	N/A
1. Does the midwife manage patients positive for Plasmodium falciparum according to DOH protocol?			

H. Midwife Advises Patient to Follow-Up on Days 7, 21 and 28	YES	NO	N/A
1. Does the midwife advise patients positive for Plasmodium falciparum and who has undergone treatment to return for follow-up on days 7, 21 and 28?			

I. Midwife Refers Patient for Repeat Malarial Smear Examination	YES	NO	N/A
1. Does the midwife refer patients showing poor response to treatment for repeat malarial blood smear examination?			

J. Midwife Gives Patient Post-Treatment Health Education	YES	NO	N/A
1. Does the midwife give patients showing good response to treatment post-treatment health education?			

K. Midwife Reviews the Results of the Malarial Smear Examination	YES	NO	N/A
1. Does the midwife review the results of repeat malarial smear examination?			

L. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer patients showing poor response to treatment and were found to be negative for Plasmodium falciparum after the repeat malarial blood smear examination to the doctor for further evaluation and management?			

K. Midwife Classifies and Treats Patient According to Guidelines	YES	NO	N/A
1. Does the midwife classify patients according to the grading of response?			
a. Adequate clinical response			
b. Early treatment failure			
c. Late clinic-parasitological failure			
d. Late parasitological failure			

	YES	NO	N/A
1. Does the midwife treat patients with parasitological treatment failures according to DOH protocols?			

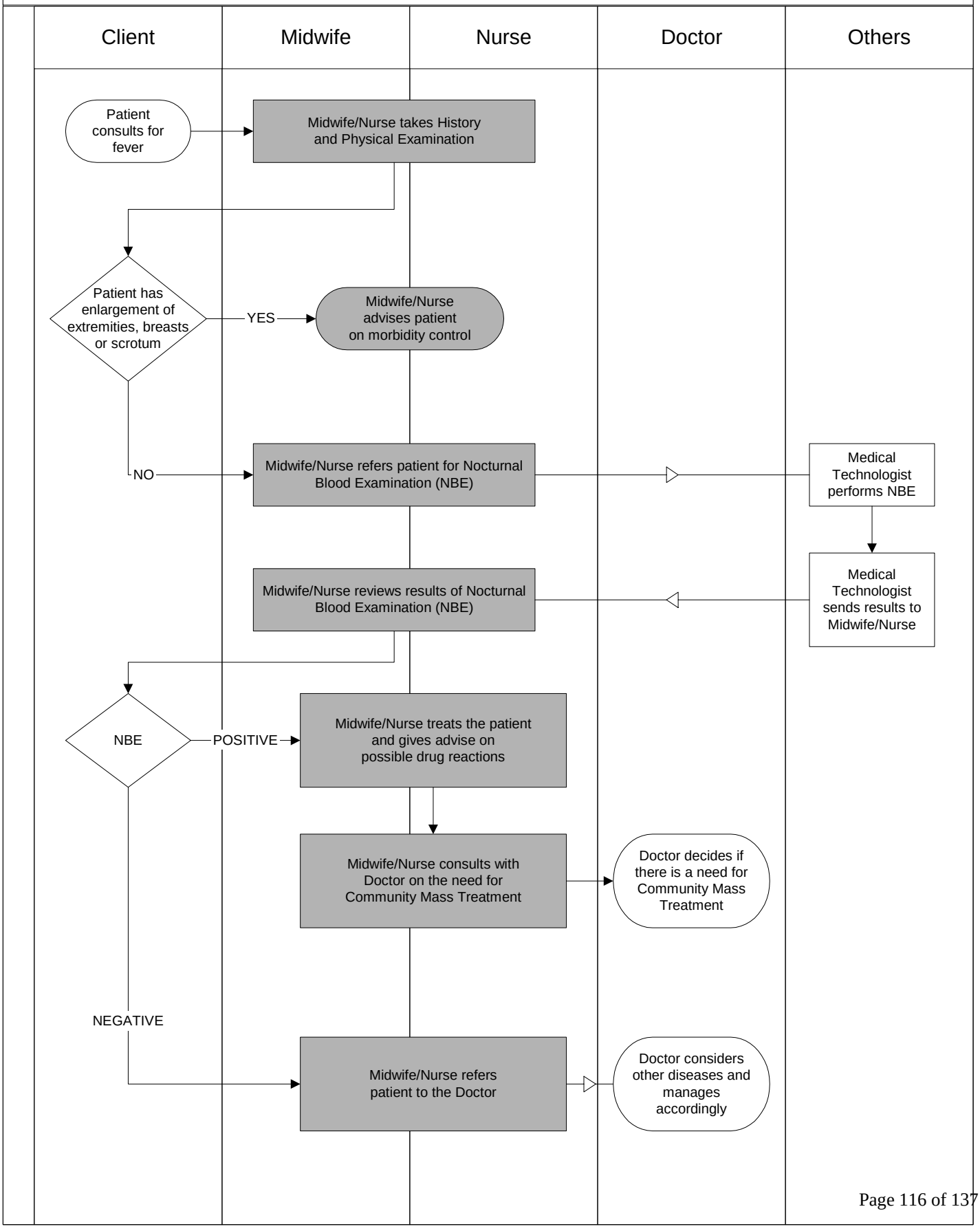
Table 4. Dose and schedule of Artemether-Lumefantrine (20 mg and 120 mg respectively)

Schedule of Treatment	***Adults and Children above 13 years old***	***Pediatric***		
		9 to 13 years	***4 to 8 years***	***1 to 3 years***
Day 1	*4 tablets*	*3 tablets*	*2 tablets*	*1 tablet*
8 hours after	*4 tablets*	*3 tablets*	*2 tablets*	*1 tablet*
Day 2	*4 tablets BID*	*3 tablets BID*	*2 tablets BID*	*1 tablet BID*
Day 3	*4 tablets BID*	*3 tablets BID*	*2 tablets BID*	*1 tablet BID*
Day 4	*Give Primaquine as in Table 3*	*Give Primaquine as in Table 3*	*Give Primaquine as in Table 3*	

L. Midwife Refers Patient to the Doctor/Hospital for Further Evaluation and Management	YES	NO	N/A
1. Does the midwife refer patients still showing poor response to treatment after treatment for parasitological treatment failures to the doctor/hospital for further evaluation and management?			

M. Midwife Gives Patient Post-Treatment Health Education	YES	NO	N/A
1. Does the midwife give patients showing good response to re-treatment post-treatment health education?			

National Filariasis Elimination Program
RHU Supervisory Form for Patients Coming from Endemic Areas



National Filariasis Elimination Program
Supervisory Checklist for Patients Coming from ENDEMIC Areas

A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife elicit the following signs and symptoms from a patient presenting with fever:			
a. Cough			
b. Chills			
c. Wheezing			
d. Lymphangitis			
e. Pain and swelling of the upper and lower extremities, scrotum, inguinal area, breast, penis and/or vulva			
f. Rice-water colored urine or chyluria			
2. Does the midwife elicit history of exposure by asking for information regarding travel to or residence in a filarial endemic area?			
3. Does the midwife observe for enlargement of the extremities, breasts and/or scrotum during physical examination?			

B. Midwife Advises Patient on Morbidity Control	YES	NO	N/A
1. Does the midwife advise patients with enlargement of the extremities, breasts and/or scrotum basic morbidity control?			
a. Proper hygiene			
b. Prevention and cure of entry lesions			
c. Exercise			
d. Elevation and wearing of comfortable shoes (for those with enlargement of extremities)			

C. Midwife Refers Patient for Nocturnal Blood Examination (NBE)	YES	NO	N/A
1. Does the midwife refer filarial suspects for nocturnal blood examination?			

D. Midwife Reviews Results of Nocturnal Blood Examination (NBE)	YES	NO	N/A
1. Does the midwife review the result of the nocturnal blood examination?			

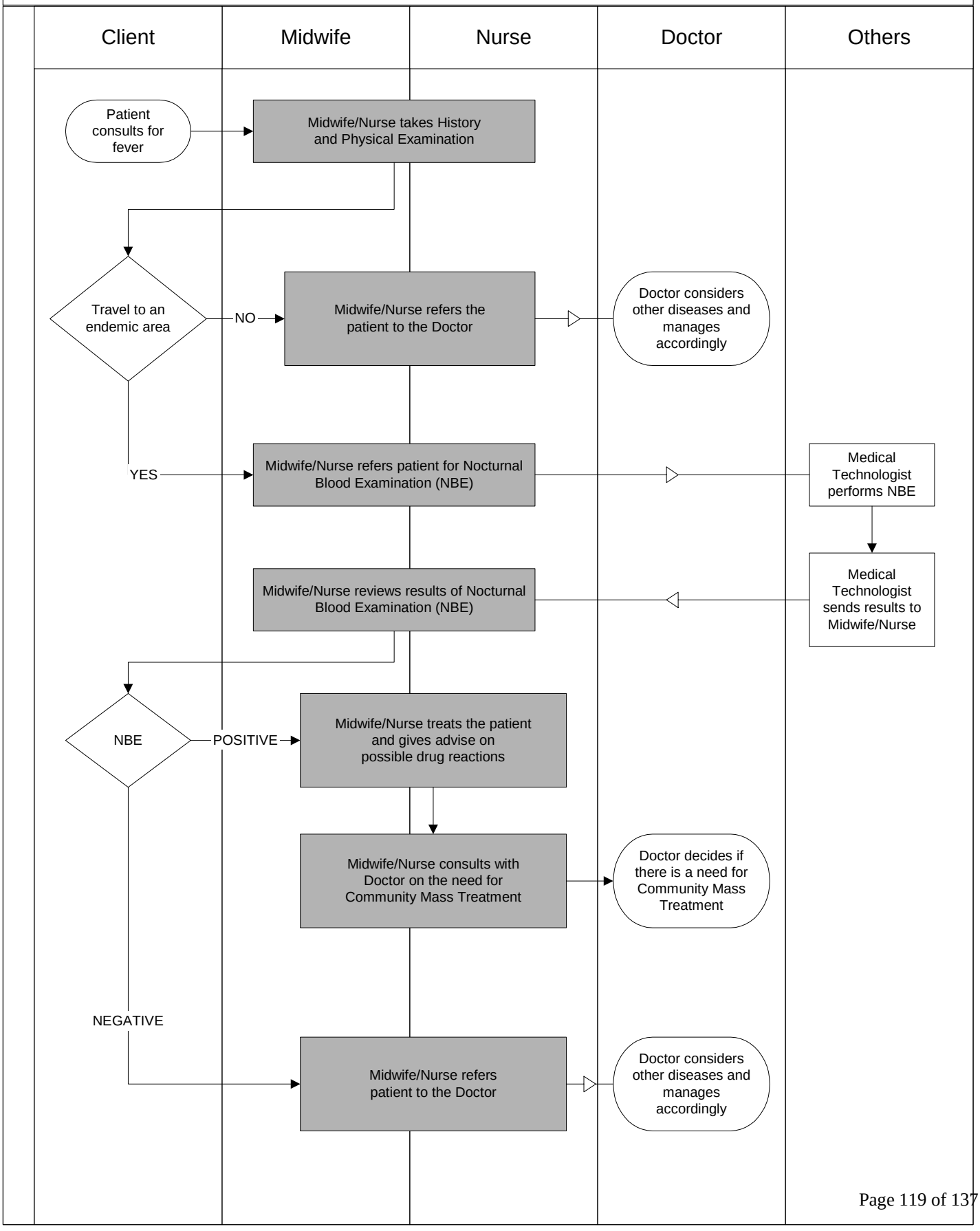
E. Midwife Treats the Patient and Gives Advise on Possible Drug Reactions	YES	NO	N/A
1. Does the midwife treat patient with positive NBE according to DOH protocols?			
Drug Regimen: Diethylcarbamazine Citrate (DEC) available as 50 mg/tablet Dose: 6 mg/kg body weight per day for 12 consecutive days in three divided doses taken after meals.			
2. Does the midwife give advise on possible drug reactions?			
a. Common Systemic Reactions			
o Headache			
o Body ache			
o Dizziness			
o Nausea or vomiting			

	YES	NO	N/A
o Urticaria			
b. Common Local Reactions			
o Lymphadenitis			
o Lymphangitis			
o Transient lymphedema			
o In male genitalia: funiculitis and epididymitis			
3. Does the midwife manage the adverse reactions symptomatically?			
4. Does the midwife advise the patient that the adverse reactions are only transient and can be managed symptomatically?			

F. Midwife Consults with Doctor on the Need for Community Mass Treatment	YES	NO	N/A
1. Does the midwife recommend to the doctor possible mass treatment of the community with newly identified cases?			

G. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer patient negative for NBE to the doctor for further evaluation and management?			

National Filariasis Elimination Program
RHU Supervisory Form for Patients Coming from Non-Endemic Areas



National Filariasis Elimination Program
Supervisory Checklist for Patients Coming from NON-ENDEMIC Areas

A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife elicit the following signs and symptoms from a patient presenting with fever:			
a. Cough			
b. Chills			
c. Wheezing			
d. Lymphangitis			
e. Pain and swelling of the upper and lower extremities, scrotum, inguinal area, breast, penis and/or vulva			
f. Rice-water colored urine or chyluria			
2. Does the midwife elicit history of exposure by asking for information regarding travel to or residence in a filarial endemic area?			
3. Does the midwife observe for enlargement of the extremities, breasts and/or scrotum during physical examination?			

B. Midwife Refers the Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer patient with no history of travel to a filarial endemic area to the doctor for further evaluation and management?			

C. Midwife Refers Patient for Nocturnal Blood Examination (NBE)	YES	NO	N/A
1. Does the midwife refer filarial suspects for nocturnal blood examination?			

D. Midwife Reviews Results of Nocturnal Blood Examination (NBE)	YES	NO	N/A
1. Does the midwife review the result of the nocturnal blood examination?			

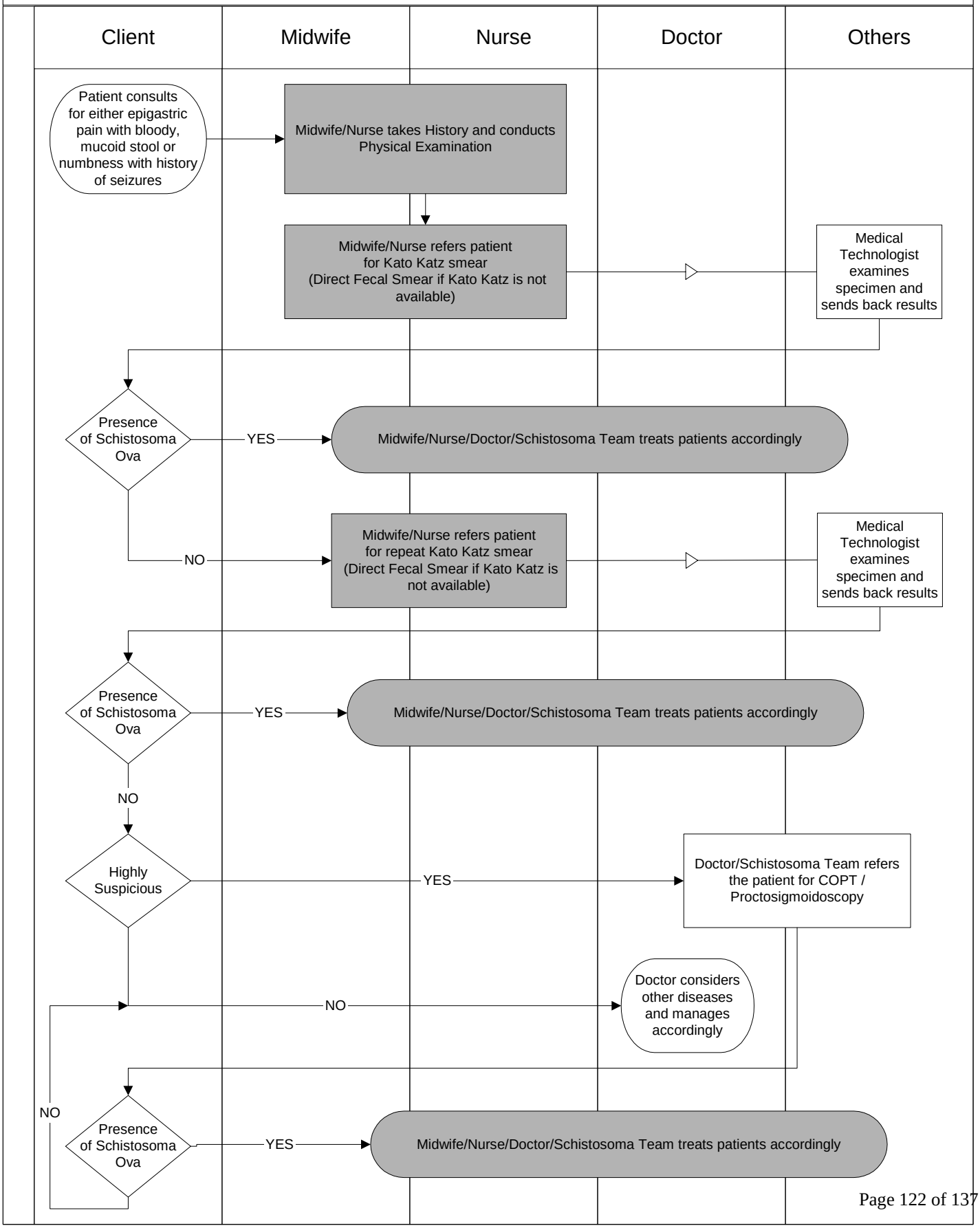
E. Midwife Treats the Patient and Gives Advise on Possible Drug Reactions	YES	NO	N/A
1. Does the midwife treat patient with positive NBE according to DOH protocols?			
Drug Regimen: Diethylcarbamazine Citrate (DEC) available as 50 mg/tablet Dose: 6 mg/kg body weight per day for 12 consecutive days in three divided doses taken after meals.			
2. Does the midwife give advise on possible drug reactions?			
a. Common Systemic Reactions			
o Headache			
o Body ache			
o Dizziness			
o Nausea or vomiting			
o Urticaria			

b. Common Local Reactions	YES	NO	N/A
o Lymphadenitis			
o Lymphangitis			
o Transient lymphedema			
o In male genitalia: funiculitis and epididymitis			
3. Does the midwife manage the adverse reactions symptomatically?			
4. Does the midwife advise the patient that the adverse reactions are only transient and can be managed symptomatically?			

F. Midwife Consults with Doctor on the Need for Community Mass Treatment	YES	NO	N/A
1. Does the midwife recommend to the doctor possible mass treatment of the community with newly identified cases?			

G. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer patient negative for NBE to the doctor for further evaluation and management?			

National Schistosomiasis Prevention and Control Program
RHU Supervisory Flowchart for Clients Coming from Endemic Areas



National Schistosomiasis Prevention and Control Program
Supervisory Checklist for Patients Coming from ENDEMIC Areas

A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife elicit the following signs and symptoms from the patient during history taking:			
a. Abdominal type			
• Epigastric or right hypochondriac pain			
• Bloody-mucoid stools			
• Pallor			
• Occasional or recurring diarrhea and dysentery			
• Emaciation			
• Body malaise			
b. Cerebral type			
• Epileptic seizure of the Jacksonian type			
• Numbness			
• Body malaise			

B. Midwife Refers Patient for Kato Katz Smear (Direct Fecal Smear if Kato Katz is not available)	YES	NO	N/A
1. Does the midwife refer schistosomiasis suspects for kato katz smear?			
2. Does the midwife refer schistosomiasis suspects for direct fecal smear when kato katz smear is not available?			
3. Does the midwife advise the schistosomiasis suspect to submit a thumb sized stool sample for the kato katz/direct fecal smear examination?			

C. Midwife Treats Patient Accordingly	YES	NO	N/A
1. Does the midwife treat abdominal type of schistosomiasis according to DOH protocols?			
Praziquantel 600 mg tablet given at 40 mg/kg body weight to be taken in 2 divided doses in just one day.			
2. Does the midwife instruct the patient to stay in the RHU/HC while Praziquantel is administered to observe for possible side reactions?			
3. Does the midwife look out for the following side reactions to Praziquantel?			
a. Stomach pains			
b. Allergy			
c. Headache			
d. Nausea and/or vomiting			
e. Dizziness			
f. Fever/Malaise			
g. Hypertension			
4. Does the midwife provide symptomatic treatment for side reactions?			
5. Does the midwife reassure the patient that side reactions respond to symptomatic treatment?			
6. Does the midwife know that Praziquantel is contraindicated with anti-convulsants?			

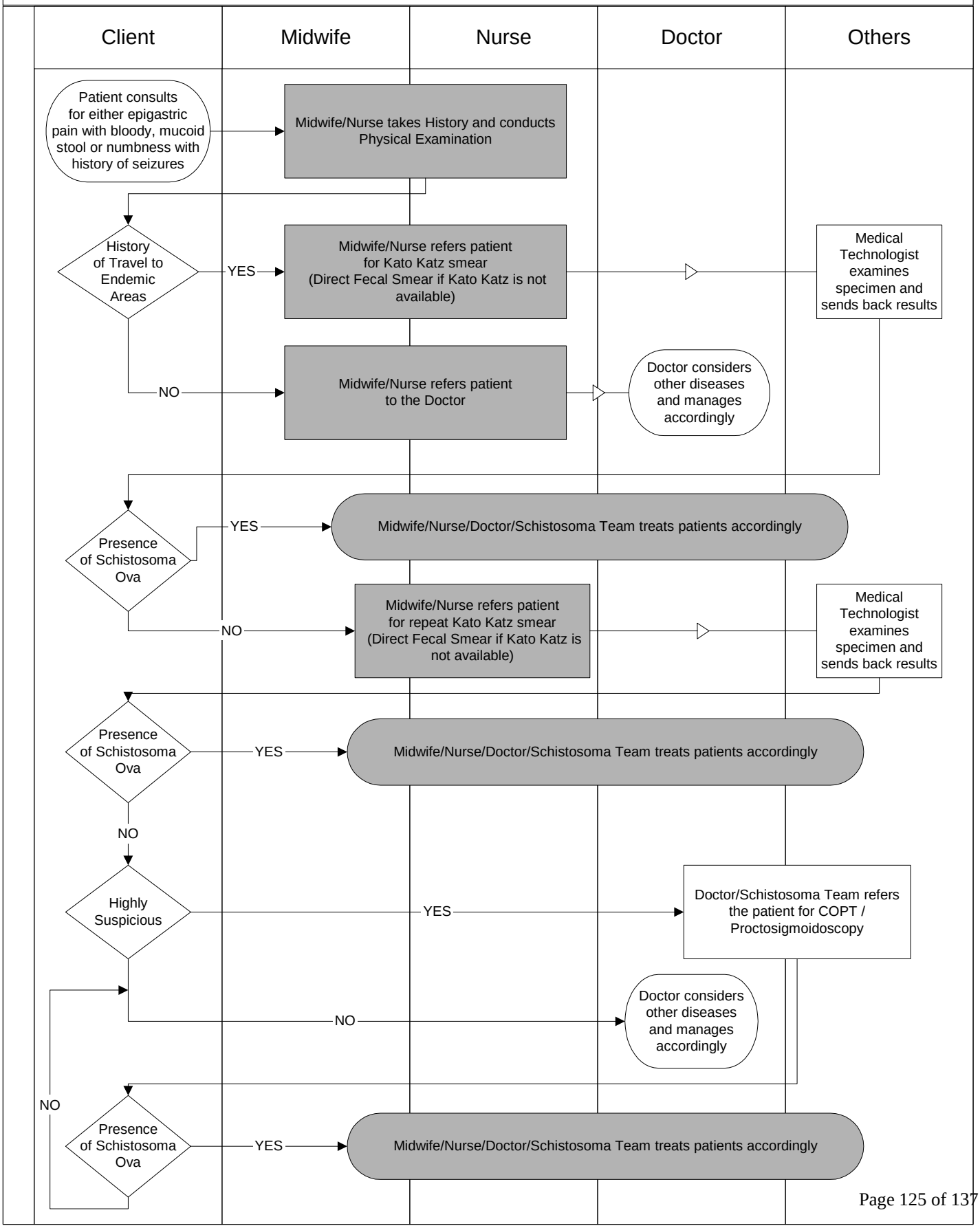
	YES	NO	N/A
7. Does the midwife refer patients with hypertension to the hospital for proper management?			
8. Does the midwife instruct breastfeeding patients to refrain from feeding their infants within the next 72 hours after intake of Praziquantel?			
9. Does the midwife refrain from giving Praziquantel to pregnant patients during their 1st trimester of pregnancy?			
10. Does the midwife treat cerebral cases of schistosomiasis according to DOH protocols?			
a. First treat the seizure/s with Dilantin 100 mg i. First week: give TID ii. Second week: give BID iii. Third week: give once a day iv. Fourth week: give every other day			
b. Once seizure is controlled, give Praziquantel 600 mg at 60 mg/kg body weight as a single dose.			
c. Give the patient Vitamin B complex supplementation.			

D. Midwife Refers Patient for Repeat Kato Katz Smear (Direct Fecal Smear if Kato Katz is not available)	YES	NO	N/A
1. Does the midwife refer the patient for repeat kato katz smear (direct fecal smear if kato katz is not available) if the first examination result was negative for schistosoma ova?			

E. Midwife Treats Patient Accordingly (after repeat examination)	YES	NO	N/A
1. Does the midwife treat patient positive for schistosoma ova during the repeat kato katz examination/direct fecal smear according to DOH protocols?			
• *Go to checklist of Letter C. Midwife Treats Patient Accordingly*			

F. Midwife Treats Patient Accordingly (after COPT/Proctosigmoidoscopy)	YES	NO	N/A
1. Does the midwife treat patient positive for schistosoma ova during COPT/Proctosigmoidoscopy according to DOH protocols?			
• *Go to checklist of Letter C. Midwife Treats Patient Accordingly*			

National Schistosomiasis Prevention and Control Program
RHU Supervisory Flowchart for Clients Coming from Non-Endemic Areas



National Schistosomiasis Prevention and Control Program
Supervisory Checklist for Patients Coming from NON-ENDEMIC Areas

A. Midwife Takes History and Conducts Physical Examination	YES	NO	N/A
1. Does the midwife elicit the following signs and symptoms from the patient during history taking:			
Abdominal type			
• Epigastric or right hypochondriac pain			
• Bloody-mucoid stools			
• Pallor			
• Occasional or recurring diarrhea and dysentery			
• Emaciation			
• Body malaise			
Cerebral type			
• Epileptic seizure of the Jacksonian type			
• Numbness			
• Body malaise			
2. Does the midwife elicit history of travel to endemic areas?			

B. Midwife Refers Patient for Kato Katz Smear (Direct Fecal Smear if Kato Katz is not available)	YES	NO	N/A
1. Does the midwife refer schistosomiasis suspects for kato katz smear?			
2. Does the midwife refer schistosomiasis suspects for direct fecal smear when kato katz smear is not available?			
3. Does the midwife advise the schistosomiasis suspect to submit a thumb sized stool sample for the kato katz/direct fecal smear examination?			

C. Midwife Refers Patient to the Doctor	YES	NO	N/A
1. Does the midwife refer patients with no history of travel to endemic areas to the doctor for further evaluation and management?			

D. Midwife Treats Patient Accordingly	YES	NO	N/A
1. Does the midwife treat abdominal type of schistosomiasis according to DOH protocols?			
Praziquantel 600 mg tablet given at 40 mg/kg body weight to be taken in 2 divided doses in just one day.			
2. Does the midwife instruct the patient to stay in the RHU/HC while Praziquantel is administered to observe for possible side reactions?			
3. Does the midwife look out for the following side reactions to Praziquantel?			
a. Stomach pains			
b. Allergy			
c. Headache			
d. Nausea and/or vomiting			
e. Dizziness			

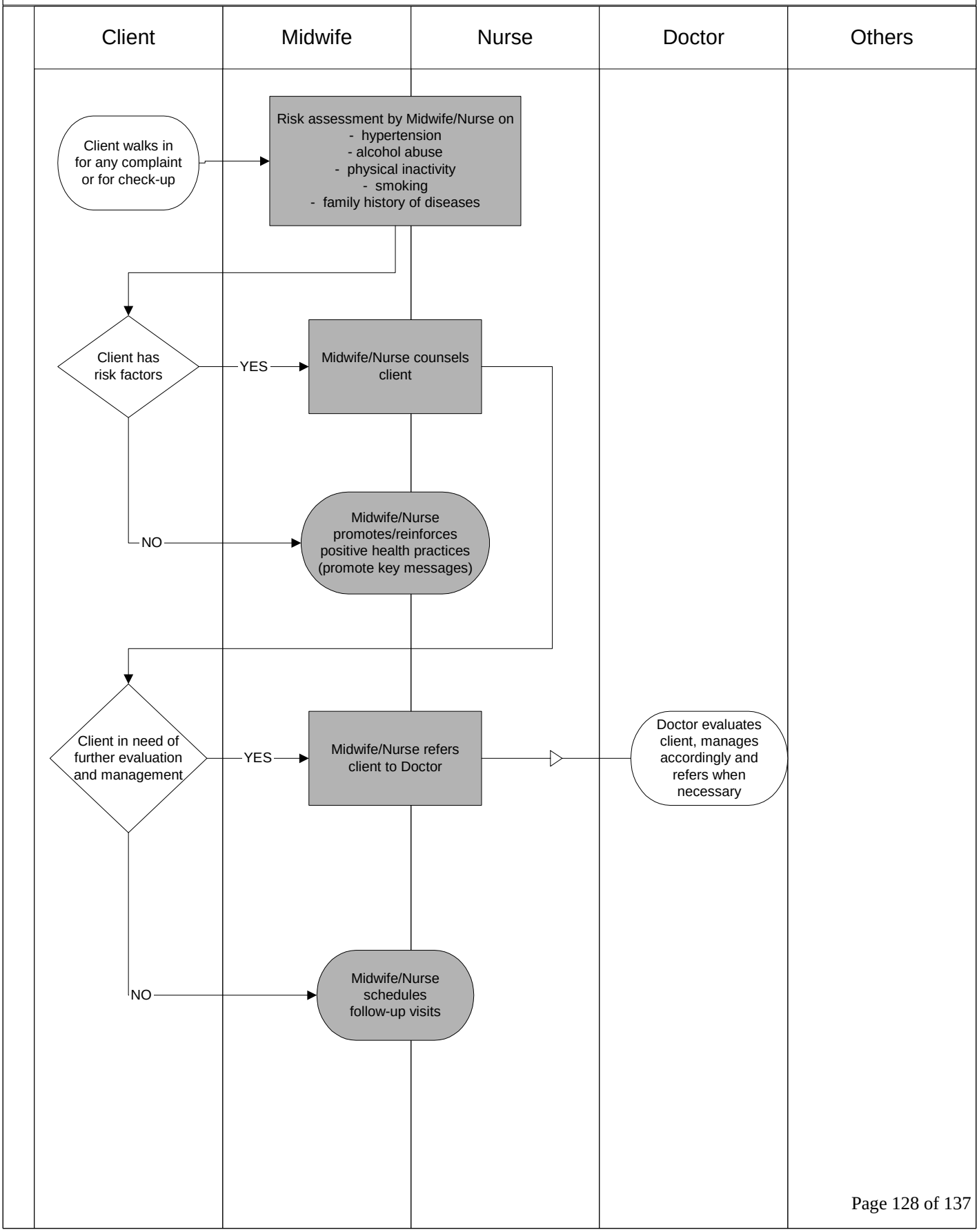
	YES	NO	N/A
f. Fever/Malaise			
g. Hypertension			
4. Does the midwife provide symptomatic treatment for side reactions?			
5. Does the midwife reassure the patient that side reactions respond to symptomatic treatment?			
6. Does the midwife know that Praziquantel is contraindicated with anti-convulsants?			
7. Does the midwife refer patients with hypertension to the hospital for proper management?			
8. Does the midwife instruct breastfeeding patients to refrain from feeding their infants within the next 72 hours after intake of Praziquantel?			
9. Does the midwife refrain from giving Praziquantel to pregnant patients during their 1st trimester of pregnancy?			
10. Does the midwife treat cerebral cases of schistosomiasis according to DOH protocols?			
a. First treat the seizure/s with Dilantin 100 mg i. First week: give TID ii. Second week: give BID iii. Third week: give once a day iv. Fourth week: give every other day			
b. Once seizure is controlled, give Praziquantel 600 mg at 60 mg/kg body weight as a single dose.			
c. Give the patient Vitamin B complex supplementation.			

D. Midwife Refers Patient for Repeat Kato Katz Smear (Direct Fecal Smear if Kato Katz is not available)	YES	NO	N/A
1. Does the midwife refer the patient for repeat kato katz smear (direct fecal smear if kato katz is not available) if the first examination result was negative for schistosoma ova?			

E. Midwife Treats Patient Accordingly (after repeat examination)	YES	NO	N/A
1. Does the midwife treat patient positive for schistosoma ova during the repeat kato katz examination/direct fecal smear according to DOH protocols?			
• *Go to checklist of Letter C. Midwife Treats Patient Accordingly*			

F. Midwife Treats Patient Accordingly (after COPT/Proctosigmoidoscopy)	YES	NO	N/A
1. Does the midwife treat patient positive for schistosoma ova during COPT/Proctosigmoidoscopy according to DOH protocols?			
• *Go to checklist of Letter C. Midwife Treats Patient Accordingly*			

Promotion of Healthy Lifestyle
RHU Supervisory Flowchart



Promotion of Healthy Lifestyle
Supervisory Checklist

A. Client Walks In For Any Complaint	YES	NO	N/A
1. Does the midwife establish rapport with all clients walking in for any complaint by:			
a. Providing privacy as much as possible?			
b. Establishing pleasantries with client to start conversation?			
c. Showing sincere concern in helping client improve health problems?			
d. Being polite to client?			
e. Allowing client to express ideas and feelings?			
f. Answering client's inquiries?			
g. Establishing eye contact?			

B. Risk Assessment by Midwife

1. Modifiable Risk Factors	YES	NO	N/A
a. Does the midwife screen clients for ***hypertension*** by taking their blood pressure?			
b. Does the midwife screen clients for ***cigarette/tobacco smoking*** by asking for the following:			
i. Current smoker			
i. Number of sticks per day			
ii. Age started smoking			
iii. Number of quit attempts			
iv. Any desire to quit			
ii. Ex-smoker			
i. Age started smoking			
ii. Age when he/she quitted			
iii. Number of sticks smoked/day at time of regular smoking			
c. Does the midwife screen clients for ***alcohol abuse*** by asking for the following:			
i. Type of alcohol (beer, wine, distilled spirit, etc.)			
ii. Frequency of drinking (day, week, month)			
iii. Usual amount of intake			
iv. Number of times clients had 5 drinks in one occasion in the past month			
v. Driving a vehicle while intoxicated in the past month			
vi. Operating a machine while intoxicated in the past month			

d. Does the midwife screen clients for ***inactivity/sedentariness*** by asking for the following:	YES	NO	N/A
i. Type of work/occupation			
ii. Activities other than work (e.g. hobbies, leisure, etc)			
iii. Means of travel to work			
e. Does the midwife screen the clients for ***obesity*** by calculating for the BMI?			

2. Non-Modifiable Risk Factors	YES	NO	N/A
a. Does the midwife screen clients for non-modifiable risk factors by asking for the following:			
i. ***Age*** in years			
ii. ***Sex*** (male or female)			
iii. ***Family history*** for:			
i. Hypertension			
ii. Cardiovascular Diseases			
iii. Diabetes mellitus			
iv. Asthma			
v. Cancer			

C. Midwife Promotes/Reinforces Positive Health Practices (Promote Key Messages)

1. Diet and Nutrition	YES	NO	N/A
a. Does the midwife promote the following messages on balanced diet?			
i. Eating a balanced diet according to one's age, height, weight, type of physical activity and physiological condition is good for health.			
ii. Balanced diet means eating a variety of food from each food group at the right amount needed by the body to maintain optimum health and nutrition.			
iii. To prevent lifestyle related diseases, it is recommended that diet includes liberal amount of vegetables and fruits (5 or more servings per day) and reduce amount of salt, sugar and animal/saturated fat.			
b. Does the midwife promote messages that correlate eating habits and prevention of diseases?			
i. Reducing salt and animal/saturated fat (fats that solidify at room temperature) intake prevents hypertension.			
ii. Reducing sugar and animal/saturated fat (fats that solidify at room temperature) intake prevents obesity and diabetes.			
iii. Increasing consumption of fruits and vegetables prevents cancer and cardiovascular diseases.			
c. Does the midwife promote diet in relation to physical activity?			
i. Amount of food intake among children and elderly are less compared to adolescents and adults.			
ii. To maintain ideal body weight, the amount of food consumed should be proportionate to level of physical activity.			
iii. Sedentary individuals should consume less amount of food than those who are physically active.			

2. Physical Activity	YES	NO	N/A
a. Does the midwife promote the following messages on physical activity?			
i. Be active in as many ways as you can.			
ii. Put at least 30 minutes of moderate physical activity preferably everyday. This will provide you with many health and wellness benefits.			
iii. Moderate physical activity refers to any activity equal in intensity to a brisk walk.			
iv. For extra health benefit and fitness, engage in more vigorous physical activities for at least 20 minutes, 3 to 4 times a week.			
v. Vigorous physical activities are those that make you “huff and puff”.			
vi. For those who have health problems or previously sedentary, consult your physician before you engage in vigorous physical activities.			
vii. Regulate/reduce amount of TV time for children and adults.			
viii. Encourage active play in children.			

3. Alcohol Use	YES	NO	N/A
a. Does the midwife promote the following health messages on alcohol use?			
i. Alcohol abuse is bad for health.			
ii. If you drink, drink moderately if there is no contraindication.			
iii. Drinking in moderation means not exceeding alcohol consumption of two units per day.			
iv. Seek professional help if you have difficulty controlling your alcohol consumption.			

4. Tobacco Use	YES	NO	N/A
a. Does the midwife discourage smoking with the following messages?			
i. Don’t smoke. If you do, quit now!			
ii. Smoking kills. Half of long-term smokers will die from smoking-related diseases.			
iii. Don’t smoke especially when there are children and other people around.			
iv. Every cigarette smoked cuts at least 5 minutes of life on average, about the time taken to smoke.			
v. Smoking is the prime factor in heart disease, stroke and chronic lung disease; causes cancer of the lungs, larynx, esophagus, mouth, and bladder; contributes to cancer of the cervix, pancreas and kidneys.			
vi. YOU CAN QUIT SMOKING!			
vii. SEEK HELP IF YOU WANT TO STOP!			

D. Midwife Counsels Client (on Risk Factors)

1. Does the midwife provide counseling to identified at-risk patients in the following manner:	YES	NO	N/A
a. Establishes goal of the session with client?			
b. Asks questions to elicit more information necessary in the assessment of risk factors relative lifestyle?			
c. Shares with client identified risk factors?			
d. Discusses with client the need to do some changes in lifestyle relative to identified risk factors?			
e. Make a contract with client to do some changes in lifestyle relative to identified risk factors?			
f. Reinforces client's positive health practices?			
g. Demand commitment from the client?			
h. Provide follow-up support?			
i. States correctly appropriate messages for specific lifestyle risk?			

2. Does the midwife provide counseling to identified at-risk clients?	YES	NO	N/A
a. Overweight/Obesity			
i. Reduce weight.			
ii. Increase amount of physical activity.			
iii. Increase intake of high fiber diet – water, fruits, legumes, vegetables, whole grain cereals, lean meat, fish.			
iv. Limit intake of sugar, salt and fat.			
v. Avoid high-caloric low-nutrient value and preserved food (e.g. junk foods, instant noodles, soft drinks, etc)			
vi. Seek the help of a nutritionist-dietitian for a more precise diet prescription.			
b. Physical Inactivity			
i. Increase physical activity.			
ii. Evaluate type of activity being done everyday and start modifying them to include more instances of physical activities.			
iii. Start with a walking regimen for at least 30 minutes daily.			
iv. Moderate physical activity of at least 30 minutes most days of the week.			
v. Integrating physical activity and exercise into regular day today activities.			
c. Smoking			
i. Advise to stop immediately.			
ii. Assist patient using smoking cessation techniques.			
d. Alcohol Abuse			
i. Assist patient to seek professional help to stop alcohol abuse.			

E. Midwife Refers Clients in Need of Further Evaluation and Management to the Doctor	YES	NO	N/A
1. Does the midwife refer clients in need of further evaluation and management to the Doctor?			

F. Midwife Schedules Follow-Up Visits	YES	NO	N/A
1. Does the midwife discuss with the client the schedule when he/she will be expected to return for follow-up visits?			

FINDINGS, ACTIONS AND RECOMMENDATIONS SECTION

Date	Area	Findings	Actions Taken	Recommendations

FINDINGS, ACTIONS AND RECOMMENDATIONS SECTION

Date	Area	Findings	Actions Taken	Recommendations

FINDINGS, ACTIONS AND RECOMMENDATIONS SECTION

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